MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (462)

05131

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Washington Sanitarium Hospital

How long in hospital or institution? 2 mo 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4 Crescent Place
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Miss Grace Amadon

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 24-1872

8. AGE:

Years	Months	Days	If less than one day
73	2	28	hrs. min.

9. Birthplace Battle Creek, Michigan
(Town, county, and state)

10. Usual occupation Research

11. Industry or business Gen. Conf. of S.D.A.

FATHER 12. Name George W. Amadon

13. Birthplace Watertown, N.Y.

MOTHER 14. Maiden name Martha Bevington

15. Birthplace St. Lawrence Co. N.Y.

16. Informant Records Washington Sanitarium

Address Takoma Park, Md.

17. Cremation Date thereof May 25 '45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill Cemetery

Location Prince George County, Md.

18. Funeral director J. Arthur Wallace

Address 254 Carroll St. Takoma Park D.C.

19. MAY 23 1945 19 J. Wm. Rodell
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 19 45 at 11:50 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 1 19 45 to May 22 19 45 and that I last saw h.. alive on May 21 19 45

	DURATION
Immediate cause of death Acute Congestive Cardiac Failure	Terminal
Due to	
Due to	
Other conditions Carcinoma of Colon	2 Months

(Include pregnancy within 3 months of death)

Major findings of operations Mass about Colon - Descending

Date of op. May 14 '45

Autopsy results Confirm physical findings

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert A Hare M.D.
M. D. or other

Address Takoma Park Md Date signed 5/23/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05132

Reg. Dist. No. 223-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2½ days
Hospital, institution, or street address where death occurred: Washington Sanitarium Hospital
How long in hospital or institution? 2½ days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8716 Colesville Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Mary C. Backus

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Mr. John Backus

6.(c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.) Feb. 12, 1909

8. AGE: Years	Months	Days	If less than one day
36	3	16	..... hrs. ..... min.

8. Birthplace Mayville, New York
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Own Home
FATHER 12. Name Adam Hersperger
13. Birthplace Bellevue, Pittsburg, Pa.
MOTHER 14. Maiden name Mabel Wright
15. Birthplace Remington, Pa
16. Informant Records, Washington San. Hosp.
Address Takoma Park, Md.
17. removal (Burial, cremation, or removal. Which?) Date thereof 5-29-45 (month) (day) (year)
Cemetery or crematory
Location Mayville - N.Y.
18. Funeral director Howard E. Pumphrey.
Address 8403 Ga Ave - Silver Spring Md
19. May 28 1945 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 1945 at 12 9 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-25 1945 to May 28 1945
and that I last saw h.. alive on May 27 1945

Immediate cause of death	DURATION
Cerebral embolism (multiple)	3 days
Due to Endocarditis (bacterial)	Months
or Rheumatic	
Due to	
Other conditions Thrombosis of	Months
pulmonary artery & atelectasis of lung	
(Include pregnancy within 3 months of death)	

Major findings of operations
Date of op.
Autopsy results as above.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John G. Brumberger M.D.
M.D. or other
Address Takoma Park Date signed 5-29-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83)

05133

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:
County: Montgomery Co.
City or town: Somerset
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 27 years
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Somerset
(If outside city or town limits, write RURAL and give nearest town)
Street No. 19 Dorset Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME Clair Cortlandt Barnes

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

8.(b) Name of husband or wife: Louna Barnes
6.(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): April 14, 1867

8. AGE: Years	Months	Days	If less than one day
78	0	24	hrs. min.

9. Birthplace: Cambridge, Ohio (Town, county, and state)
10. Usual occupation: Printer
11. Industry or business:
FATHER 12. Name: Milton Barnes
13. Birthplace: Ohio
MOTHER 14. Maiden name: Rhoda Allison
15. Birthplace: Pennsylvania
16. Informant: Mrs. Louna Barnes
Address: 19 Dorset Av. Chevy Chase Md.
17. (Burial, cremation, or removal. Which?) Date thereof: May 10 - 1945 (month) (day) (year)
Cemetery or crematory: Ft Lincoln
Location:
18. Funeral director: Joseph Davis Sons
Address: 1726 - Pa. Ave. N.W. Washington D.C.
19. 5/8/45 (Date rec'd by registrar) Wm E Johns Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 8 1945, at 8 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 25 1945 to May 8 1945 and that I last saw him alive on May 8, 1945
Immediate cause of death: Cerebral Hemorrhage — DURATION: 3 days
Due to: Chr. Osteosclerosis — 10 yrs
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: E. B. Bauerfeind M. D. or other
Address: Bethesda, Md. Date signed: 5/8/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05134

Reg. Diat. No. 212

1. PLACE OF DEATH:
County Montgomery
City or town Barnesville, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 Weeks
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Boyd - Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: William Lincoln Barr

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Emma Barr
6.(c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.): Feb 11 - 186 4

8. AGE:

Years	Months	Days	If less than one day
81	3	1	hrs. min.

9. Birthplace: Maytown Pa (Town, county, and state)
10. Usual occupation: Retired Merchant
11. Industry or business
FATHER 12. Name: Wm S. Barr
13. Birthplace: Pa.
MOTHER 14. Maiden name: Eliza Elliott
15. Birthplace: Pa.
16. Informant: Bryan Barr
Address: Barnesville, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/14/45 (month) (day) (year)
Cemetery or crematory: Monocacy
Location: Beallsville, Md
18. Funeral director: William B. Hilton
Address: Barnesville, Md
19. May 13 1945 (Date rec'd by registrar) Mrs. C.C. Hilton By Mrs. to C.B. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 12 - 1945, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 12 - 1945, to May 12 1945
and that I last saw h[illegible] alive on May 12 - 1945

	DURATION
Immediate cause of death: Acute dilitation of heart	6 hrs.
Due to: Chronic myocarditis	
& degeneration	5 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Bryan D. White, M.D.
M. D. or other
Address: Poolesville, Md Date signed 5/14/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

CERTIFICATE OF DEATH

05135

Reg. Dist. No. 214

1. PLACE OF DEATH:

County MONTGOMERY

City or town SILVER SPRING (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

~~Hospital, institution, or~~ street address where death occurred:

1005 N. NOYES DRIVE

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State MARYLAND County MONTGOMERY

City or town SILVER SPRING (If outside city or town limits, write RURAL and give nearest town)

Street No. 1005 N. NOYES DR. (If rural, give LOCATION)

2.(a) If veteran, name war NONE

3. (a) FULL NAME JOHN E. BLADES.

3. (b) Social Security Number NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of ~~husband or~~ wife MARGARET A.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) MARCH 26TH 1878

8. AGE: Years	Months	Days	If less than one day
67	1	15	..... hrs. ..... min.

9. Birthplace OXFORD, MD (Town, county, and state)

10. Usual occupation RETIRED

11. Industry or business

FATHER 12. Name WILLIAM BLADES

13. Birthplace MD

MOTHER 14. Maiden name SARAH CARROW

15. Birthplace MD

16. Informant MRS MARGARET A. BLADES

Address 1005 N. NOYES DR. SILVER SPRING

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof MAY 14 45 (month) (day) (year)

Cemetery or crematory PROSPECT HILL

Location WASHINGTON, D.C.

18. Funeral director Warren E. Pumphrey

Address SILVER SPRING, MD

19. May 14 1945 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 11 1945 at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MAY 7 1945, to MAY 11 1945 and that I last saw h IM alive on MAY 9 1945

Immediate cause of death	DURATION
CONGESTIVE HEART FAILURE	2 MOS.
Due to CORONARY ARTERIOSCLEROTIC HEART DISEASE	8 YRS.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statisticaDy.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Hugh Hudson Hussey M.D. M. D. or other

Address 900 - 17TH ST. N.W. WASHINGTON, D.C. Date signed 5/12/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (85-a)

CERTIFICATE OF DEATH

T 05136

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 hours & 25 minutes
Hospital, Institution, or street address where death occurred:
U.S.Naval Hospital, Bethesda, Md.
How long in hospital or institution? 9 hours ' 25 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Va. County: Arlington
City or town: Arlington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 307 N.Granada St.
(If rural, give LOCATION)
2.(a) If veteran, name war: V

3. (a) FULL NAME: BLANCHARD, Leland Dwight, Lt. Comdr. USNR

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Margaret Blanchard
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 4-15-03

8. AGE: Years	Months	Days	If less than one day
42	1	5	hrs. min.

9. Birthplace: ohio (Town, county, and state)
10. Usual occupation: Navy
11. Industry or business

FATHER
12. Name: Lee Blanchard
13. Birthplace: Ohio (dec.)

MOTHER
14. Maiden name: Laura ?
15. Birthplace: Ohio (dec.)

16. Informant: Wife: Mrs. Margaret Blanchard
Address: 307 N. Granada St., Arlington, Va.

17. removal (Burial, cremation, or removal. Which?) Date thereof 5-21-45 (month) (day) (year)
Cemetery or crematory: West Lawn
Location: Canton, Ohio
18. Funeral director: W. W. Chambers Wa MacLean
Address: 1400 Chapin St., N.W., Wash., D.C.

19. 21 May 45 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 20, 1945 19.... at 11:35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/20/45 19.... to 5/20/45
and that I last saw h.. alive on 10:30 PM 5/20 19 45

Immediate cause of death	DURATION
cerebral hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: L. D. Blanchard M.D.
M. D. or other
Address: U.S. Naval Hosp. Bethesda Md. Date signed 5/20/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

05137

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: MONTGOMERY

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? five hours

Hospital, Institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Md.

How long in hospital or institution? five hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 46 Galveston Place, S. W., Apt. 20
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: BOOTH, William Samuel, Lt.(jg)(E) USNR

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 18 September 1920

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
24	7	15		

9. Birthplace: ohio
(Town, county, and state)

10. Usual occupation: Navy

11. Industry or business:

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Wife: Mrs. Wm. S. Booth,
Address: 46 Galveston Place, S. W., Wash., D.C.

17. removal (Burial, cremation, or removal. Which?) Date thereof: 5-4-45 (month) (day) (year)

Cemetery or crematory: North Wood Cemetery

Location: Cambridge, Ohio

18. Funeral director: W. W. Chambers, per R. E. Tolar

Address: 1400 Chapin St., N. W., Wash., D.C.

19. 4 May 19 45 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3 May 19 45, at 7 55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 30 pm 3 May 19 45, to 7 55 pm 3 May 19 45

and that I last saw h. alive on 3 May 19 45

Immediate cause of death	DURATION
Diabetes Mellitus (Coma)	4 hours
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert M. Cobb Lt MC USNR
M. D. or other

Address: USNH - Bethesda - Date signed: 5-4-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17-C)

CERTIFICATE OF DEATH

05138

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 days
Hospital, institution, or street address where death occurred: Suburban Hospital
How long in hospital or institution? 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 709 Gist Ave.,
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mrs. Maria Eldicia Bowie

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Gordon Bowie M.D. (deceased)
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 25, 1874

8. AGE:

Years	Months	Days	If less than one day
70	8	28	..... hrs. ..... min.

9. Birthplace: Newland, Richmond Co., Virginia
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Oscar Pope Morris
13. Birthplace: Newland, Virginia

MOTHER
14. Maiden name: Mary Amanda Saunders
15. Birthplace: Warsaw, Virginia

16. Informant: Miss Deana C. Bowie, daughter
Address: 709 Gist Ave, Silver Spring Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 28th 1945 (month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location: Prince Georges Co. Md

18. Funeral director: ~~Pumphrey~~ Warner & Pumphrey
Address: Silver Spring, Md.

19. 5/23 1945 (Date rec'd by registrar) Wm E Jarboe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5-22 1945, at 6:30A M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 1945 to May 22nd 1945 and that I last saw h.. alive on May - 1945.

Immediate cause of death	DURATION
Lung Abscess & Empyema - Rt. lower lobe	
Due to: Pulmonary Infarction (?) Aspiration Pneumonia (?)	
Due to:	
Other conditions: Duodenal Ulcer	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: See above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Richard E. Kelso M.D.
M. D. or other
Address: Suburban Hospital Date signed 5-22-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05139

Reg. Dist. No. 223-

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Three years
Hospital, institution, or street address where death occurred:
506 Carroll Avenue
How long in hospital or institution? Three weeks 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 813 Carroll Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Ella Davis Brent

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: A. Eustace Brent
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Sept. 22, 1878

8. AGE: Years	Months	Days	If less than one day
66	7	21	____ hrs. ____ min.

9. Birthplace: Kilmarnock, Va.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Home

FATHER
12. Name: William Franklin Davis
13. Birthplace: Kilmarnock, Va.

MOTHER
14. Maiden name: Ella Barnett
15. Birthplace: Kilmarnock, Va.

16. Informant: Miss Mary Hazel Brent
Address: 813 Carroll Avenue, T.P. Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 5-14-45 (month) (day) (year)
Cemetery or crematory: Cunningham Funeral Home
Location: Alexandria Va
18. Funeral director: F. Gaughan Sons
Address: Hyattsville, Md.

19. 5/17/45 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13 1945, at 9:05 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 5 1945, to May 13 1945
and that I last saw h[illegible] alive on May 13 1945

Immediate cause of death	DURATION
Uremia	6 days
Due to: Cardio-vascular-renal disease	7 yrs.
Due to: Arterial Hypertension	25 yrs.
Other conditions: Osteo-arthritis	15 years
Cerebral thrombosis	14 weeks

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Wallace N. Mook M.D.
M. D. or other
Address: 805 Carroll Ave, Takoma Park 12, Md.
Date signed: 5-13-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (836)

CERTIFICATE OF DEATH

05140

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Montgomery
City or town: Chevy Chase
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 6708 Summet, Ave
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 10 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Montgomery County:
City or town: Chevy Chase Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 6708 Summet, Ave.
(If rural give LOCATION)
2(c) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Cynthia Ann Bryant

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife: James H Bryant
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 12" 1859

8. AGE: Years	Months	Days	If less than one day
85	7	25	hrs. min.

9. Birthplace: Rock Castle, Ky
(Town, county, and state)
10. Usual occupation: none
11. Industry or business

FATHER
12. Name: Willis G Proctor
13. Birthplace: Va.

MOTHER
14. Maiden name: Mary Carson
15. Birthplace: Va.

16. Informant: Mary Lou Estes
Address: 6708 Summet, Ave. Ch.Ch. Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof May 2 1945 (month) (day) (year)
Cemetery or crematory:
Location: Chattanooga, Tenn.
18. Funeral director: Harry L Blye
Address: 1009 H, St. N.W.

19. 5/2 19 45 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 2" 19 45, at 1.35A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1 19 44, to May 2 19 45, and that I last saw h- alive on May 2 19 45.

Immediate cause of death	DURATION
Acute Heart Failure	3 days
Due to Atherosclerosis (general)	
Due to	
Other conditions Hemiplegia due to Cerebral Thrombosis	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Gilbert B. Rude M. D. or other
Address: 3900 Military rd N.W. Date signed 5/2/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

T 15141

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montg.

City or town: Kensington, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 months

Hospital, Institution, or street address where death occurred: # 7 Howard Ave. Kens. Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Montg.

City or town: Kensington, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 25 Everett St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Antonio Calvagno

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Grace

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Apr. 18, 1872

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
73				

9. Birthplace: Biancavilla, Prov. of Catania, Sicily, Italy (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business:

FATHER — 12. Name: Alfred Calvagno

13. Birthplace: Biancavilla, Prov. of Catania, Sicily, Italy

MOTHER — 14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: Mrs. Alfred C. Calvagno

Address: 25 Everett St. Kens. Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 5/12/45 (month) (day) (year)

Cemetery or crematory:

Location: Washington D.C.

18. Funeral director: Du Val Funeral Co.

Address: Washington D.C.

19. 5/12 19 45 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 12 1945, at 10:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 9 1945, to May 12 1945

and that I last saw h alive on May 12 1945

Immediate cause of death	DURATION
Coronary occlusion	died suddenly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Frank J. Bouchat M.D. Dep. Med. Exam. M. D. or other

Address: Washington, Md. Date signed: 5-12-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

05142

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlee St., Baltimore (47-f) 2

CERTIFICATE OF DEATH

Reg. Dist. No. 316

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 days
Hospital, institution, or street address where death occurred:
USNH, Bethesda, Maryland
How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1101 Massachusetts Avenue, N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: HOWARD FREDERICK R. CARLSON, LT(JG) USN ACTIVE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Hazel Carlson
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 20, 1891

8. AGE: Years	Months	Days	If less than one day
53	7	24	hrs. min.

9. Birthplace: New York (Town, county, and state)
10. Usual occupation: Navy
11. Industry or business

FATHER
12. Name: Albert Carlson
13. Birthplace: Sweden

MOTHER
14. Maiden name: Mary Miller
15. Birthplace: Sweden

16. Informant: Wife: Mrs. Hazel Carlson
Address: 1101 Massachusetts Ave. N.W., Wash. DC

17. cremation (Burial, cremation, or removal. Which?) Date thereof 5-16-45 (month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location: Washington, D. C.

18. Funeral director: W. W. Chambers
Address: 1400 Chapin St. N.W., Wash., D.C.

19. 5-14-45 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 14 May 19 45 at 2:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 May 19 45 to 14 May 19 45 and that I last saw him alive on 14 May 19 45

	DURATION
Immediate cause of death: Myelitis, Paraplegic	3 months
Due to: Metastatic carcinoma	3 months
Due to: Primary site not definitely determined, Probably in mediastinum ovary?	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Metastatic carcinoma. Date of op. 3/13/45

Autopsy results: An autopsy was not granted.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert W. Pardon M. D. or other
Address: USNH, Bethesda, Maryland Date signed: 5-14-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

CERTIFICATE OF DEATH

05143

Reg. Dist. No. 2-16

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Suburban Hospital

How long in hospital or institution? 10 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: 4706 Bethesda

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4706 Maple Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Chapman jr., Arthur Calvin

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 1, 1928

8. AGE:

Years	Months	Days	If less than one day
17	3	24	..... hrs. ..... min.

9. Birthplace: Bethesda, Montgomery, Maryland (Town, county, and state)

10. Usual occupation: on delivery truck

11. Industry or business

FATHER

12. Name: Arthur Calvin Chapman

13. Birthplace: Sardinia, Ohio

MOTHER

14. Maiden name: Julia Caton

15. Birthplace: Oakton, Virginia

18. Informant: mother.

Address: 4706 Maple Ave, Bethesda Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/28/45 (month) (day) (year)

Cemetery or crematory: Fort Lincoln Cem.

Location: Maryland

18. Funeral director: Wm Reuben Humphreys

Address: 7557 Wis. Ave. Bethesda,

19. 5/28 19 45 Wm E Todd, Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 25, 1945, at 2.40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Coroner's Case.

Immediate cause of death	DURATION
Shock and internal	
Due to: Lacerations.	
Due to: Automobile accident. C.U.S.R.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: 5/25/45

Accident, suicide, or homicide: Accident. Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work? .....

23. SIGNATURE: C. G. Bauersfeld Jr. M. D., or other

Asst. Deputy Medical Examiner for Montg. Co.

Address: Bethesda, Md. Date signed: 5/25/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

J 05144

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Garrett Park, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs.

Hospital, institution, or street address where death occurred: 36 Kenilworth Ave. Garrett Park Md

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Monty

City or town: Garrett Park Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 36 Kenilworth Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Lucy Livings Chisholm

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife: Charles F.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Apr. 20, 1871

8. AGE: Years: 74 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Theodore Livings

13. Birthplace: unknown

MOTHER 14. Maiden name: Mary Ann Jackman

15. Birthplace: unknown

16. Informant: Catherine C. Chisholm

Address: 36 Kenilworth Ave. Garrett Park

17. Disposition (Burial, cremation, or removal. Which?) Date thereof: 5/17/45 (month) (day) (year)

Cemetery or crematory: Union Cem.

Location: Chevy N. Y.

18. Funeral director: Wm Reuben Dunphrey

Address: 7557 Wis. Ave. Bethesda, Md.

19. 5/17 (Date rec'd by registrar) 19 45 Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 16 19 45 at 8:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19 40 to May 16 19 45 and that I last saw her alive on May 16 19 45

	DURATION
Immediate cause of death: Coronary Thrombosis	1 hour
Due to:	
Due to:	
Other conditions: Arteriosclerosis (Include pregnancy within 3 months of death)	Many years

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Bradley D Hodges Jones M.D. M. D. or other

Address: 313-W Bradley Ave Date signed: 5/16/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
MAY 21 1945
BUREAU V. S.

Chisholm

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

05145

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 days.

Hospital, Institution, or street address where death occurred:

Washington Sanitarium.

How long in hospital or institution? 8 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: District of Columbia County:

City or town: Washington D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2100 Conn. Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Helen Funtleroy Cockerill

3.(b) Social Security Number: 212-14-8218

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 21 1910

8. AGE: Years	Months	Days	If less than one day
34	11	25	hrs. min.

9. Birthplace: Purcellville, Virginia (Town, county, and state)

10. Usual occupation: Nurse.

11. Industry or business:

FATHER — 12. Name: Horace Mann Cockerill

13. Birthplace: (Cannot be learned) Ohio

MOTHER — 14. Maiden name: Ida Reed Stout

15. Birthplace: Stevensburg, Virginia

16. Informant: Mrs. Phillip J. Leckey

Address: 102 Allegheny Ave. Takoma Park Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: May 16 1945 (month) (day) (year)

Cemetery or crematory: Ebenezer Cemetery

Location: Purcellville, Virginia

18. Funeral director: Walter E. Fitzgerald By J. B. L.

Address: Arlington

19. MAY 16 1945 19.... (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 16, — 1945 at 9:05 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 8 — 1945 to May 16 1945 and that I last saw him alive on May 16 1945

Immediate cause of death	DURATION
Acute Dilatation of Stomach	2 hours
Due to: Manic Depressive Psychosis	3 weeks
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.:

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of: —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?): —

Means of injury: Injured at work?

23. SIGNATURE: Henry L. Brown M.D. M. D. or other

Address: Takoma Park Md. Date signed: 5/16/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

105146

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Pk. Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Montomery

City or town: Tak. Pk. Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. 100 Baltimore Av.,
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Florence W. Conger

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 25 1856

8. AGE: Years: 88 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Port Huron Mich
(Town, county, and state)

10. Usual occupation: Retired clerk - City Post Office

11. Industry or business: Washington - D.C.

FATHER
12. Name: Omar Dwight Conger
13. Birthplace: Waterville N.Y.

MOTHER
14. Maiden name: Emily Parker
15. Birthplace: N.Y.

16. Informant: Mrs A.W. Fitch
Address: 2301- Conn Ave N.W.

17. Cremation & Removal (Burial, cremation, or removal. Which?) Date thereof: May 17 1945 (month) (day) (year)

Cemetery or crematory: Ft Lincoln

Location: Port Huron, Michigan

18. Funeral director: The S.H. Hines Co.

Address: 2901-14th St. N.W.

19. May 16 1945 (Date rec'd by registrar) Josephine M. Schaffle (Registrar)

MEDICAL CERTIFICATION 5/16/45

20. DATE OF DEATH: 5-16 1945, at 1 00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-16 1945 to 5-16 1945 and that I last saw h alive on 5-15-45 1945

Immediate cause of death: Cardio-vascular-renal disease - yrs.

Due to: arteriosclerosis

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C M Hamner, M.D. M. D. or other

Address: Silver Spring, Md. Date signed: 5-16-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05147

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, Institution, or street address where death occurred:
USNH, Bethesda, Maryland

How long in hospital or Institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: California County:

City or town: Pasadena Los Angeles
(If outside city or town limits, write RURAL and give nearest town)

Street No. 175 South Hobart Blvd., Los Angeles, Cal.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME

CRUSE, Wilbur Clyde, SP(V)1c USNR

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 25, 1910

8. AGE: Years	Months	Days	If less than one day
34	10	7	hrs. min.

9. Birthplace: Indiana
(Town, county, and state)

10. Usual occupation: Navy

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Mother: Mrs. Bessie Cruse
Address: 175 South Hobart Blvd., Los A., Cal.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 5-3-45 (month) (day) (year)

Cemetery or crematory:

Location: Pasadena, California

18. Funeral director: W. W. Chambers per R E Tobin
Address: 1400 Chapin St. N.W., Washington, D.C.

19. 5-3-45 (Date rec'd by registrar) 19 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 2 19 45, at 11:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/30 19 45, to 5/2 19 45

and that I last saw him alive on 8:30 P M 5/2 19 45

Immediate cause of death: Acute cerebro spinal meningitis — DURATION: 5 days

Due to:

Due to:

Other conditions: Acute nephritis

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: G F Eckardt M. D. or other

Address: USNH Bethesda, Md. Date signed: 5-3-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

105148

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH:
County: Montgomery
City or town: Emory Grove RFD (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? All life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Emory Grove RFD
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rural
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME: Thomas F Davis

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	Married

6.(b) Name of husband or wife: Betsy Davis
6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): Dec 31 - 1874

8. AGE: Years	Months	Days	If less than one day
70	4	11	... hrs. ... min.

9. Birthplace: Montgomery Co Md (Town, county, and state)
10. Usual occupation: Labor
11. Industry or business: Farm & Home
FATHER 12. Name: Thomas Davis
FATHER 13. Birthplace: Montgomery Co Md
MOTHER 14. Maiden name: Cinda Woods
MOTHER 15. Birthplace: Montgomery Co Md
16. Informant: Betsy Davis
Address: Gaithersburg Md
17. Burial (Burial, cremation, or removal, which?) Date thereof: May 17 1945 (month) (day) (year)
Cemetery or crematory: Mt Zion Cem
Location: Near Brookeville Md
18. Funeral director: Roy W Barber
Address: Laytonsville Md
19. May 14 1945 Alvin D Cooke (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 11 1945 at 6 55 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 19... to May 11 19 1945 and that I last saw h... alive on May 9 19 45

Immediate cause of death: Carcinomatosis (Left lower extremity (Hip & leg); Metastasis to left lung.

	DURATION
Due to:	10 yrs 1 Month
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.:
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Martin D Young M D (M. D. or other)
Address: Dawsonville Md Date signed: 5/13/45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Md)

CERTIFICATE OF DEATH

05149

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? one hour
Hospital, institution, or street address where death occurred: USNH, Bethesda, Maryland
How long in hospital or institution? one hour

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 719 Sheridan St., N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: DICKERT, Wilson Chappell, CPhM USN Retired Inact.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Bessie C. Dickert
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 7 Feb. 1901

8. AGE: Years	Months	Days	If less than one day
44	3	0	hrs. min.

9. Birthplace: Georgia (Town, county, and state)
10. Usual occupation: CPh USN
11. Industry or business: Retired Inact.

FATHER
12. Name: Daniel C. Dickert
13. Birthplace: S.C.

MOTHER
14. Maiden name: Marion C. Chappell
15. Birthplace: S. C.

16. Informant: Wife: Mrs. Bessie C. Dickert
Address: 719 Sheridan St., N.W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 5-11-45 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.

18. Funeral director: S. H. Hines R.T.L.
Address: 2901 14th St., N. W., Wash., D.C.

19. 5-8 (Date rec'd by registrar) 19 45 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7 May 19 45, at 6:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7 May 19 45, to May 7 19 45
and that I last saw him alive on 7 May 19 45

Immediate cause of death	DURATION
Cerebral hemorrhage	
Due to hypertension	
Fracture of skull; due to a fall	
Due to Had arteriosclerotic disease, the result of stroke.	
Other conditions Accidental fall, the result of the stroke.	C.W.S.R.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: Cerebral hemorrhage & fracture of skull
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Acc Date of
Where did injury occur? D. C. (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Land
Means of injury: Injured at work?

23. SIGNATURE: J. B. Rahm M. D. or other
Address: USN Hosp. Bethesda Md Date signed 5-8-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

C5150

Reg. Dist. No. 214

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Mont
City or town: Wr Glenmont
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 years
Hospital, Institution, or street address where death occurred: no
How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Mont
City or town: Brookville Silver Sp. (R.F.D.)
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Wr Glenmont - Mont. Co.
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3. (a) FULL NAME: Wilton Edgar Disney

3. (b) Social Security Number: none -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	white	married

6.(b) Name of husband or wife: Belle E. Disney
6.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): Nov 10 - 1891

8. AGE: Years	Months	Days	If less than one day
53	6	5	hrs. min.

9. Birthplace: Highland - Howard Co Md (Town, county, and state)
10. Usual occupation: Garage (own)
11. Industry or business: automobile repairs -

FATHER
12. Name: Thos S. Disney
13. Birthplace: Howard Co Md -

MOTHER
14. Maiden name: Margaret E. Wilson
15. Birthplace: Edwards Mont Co Md

16. Informant: Mrs Belle E Disney
Address: Silver Sp - R 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 18 - 1945 (month) (day) (year)
Cemetery or crematory: Burtonsville Union
Location: Burtonsville Mont Co. Md
18. Funeral director: Warner & Pumphrey
Address: 8434 - Ga. Ave - Silver Spring. Md.

19. May 16 1945 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 15 - 1945, at 3 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 3 - 1945, to May 15 1945
and that I last saw him alive on May 14 - 1945

Immediate cause of death	DURATION
(a) Hypertensive Heart	
disease with nephr-	
Due to (b) Uritis -	unknown
Due to (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: no
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Chas E Tumbleson M. D. or other
Address: Sandy Spring Md Date signed: 5/15/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

C5151

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Montgomery
City or town: (If outside city or town limits, write RURAL and give nearest town)
Street No. 7310 Mass Ave. Westgate, Md
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs Muriel Saylor Doyle

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: James B
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): October 2 1896

8. AGE:

Years	Months	Days	If less than one day
48			hrs. min.

9. Birthplace: Philadelphia Pa (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: John H Saylor
13. Birthplace: Penna

MOTHER
14. Maiden name: Salome Brumm
15. Birthplace: Penna

16. Informant: James B Doyle
Address: 7310 Mass Ave, Westgate, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
Cemetery or crematory:
Location:
18. Funeral director: The D. W. Lewis Co.
Address: 1901-14 st N.W.
19. 5-13-45 (Date rec'd by registrar) 19 WE Jobe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13th 1945, at 7:45 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1942 19 to May 13th 1945
and that I last saw h.. alive on May 12th 1945

Immediate cause of death	DURATION
Carcinoma of Breast	1 year
Due to	
Due to	
Other conditions Metastasis to Lung	3 mos.

(Include pregnancy within 3 months of death)

Major findings of operation: Carcinoma of Breast
1943 Date of op. June 1943
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W B Lewis M. D. or other
Address: 1146-R St NW Date signed: 5/13/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

05152

Reg. Diat. No. 214

1. PLACE OF DEATH:
County: Montgomery
City or town: Forest Glen
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 min.
Hospital, institution, or street address where death occurred:
Sisfunary n
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Prince Georges
City or town: Capital Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No. 343 Franklin Ave 6103 Bass st.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Frank L. Dronenburg

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

B.(b) Name of husband or wife: Isabelle R. Dronenburg. B.(c) If alive, give age: 54. years

7. Birth date of deceased (mo., day, yr.): January 3, 1890

8. AGE:

Years	Months	Days	If less than one day
55	4	3	hrs. min.

9. Birthplace: Mt Ephraim Frederick County Md.
(Town, county, and state)

10. Usual occupation: Fireman

11. Industry or business

FATHER
12. Name: Reverdy Dronenburg.
13. Birthplace: Clarksburg. Md.

MOTHER
14. Maiden name: Ida. J. Ziegler
15. Birthplace: Clarksburg. Md.

16. Informant: Isabelle R. Dronenburg.
Address: 6103 Bass St. Capital Hgts Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 9 1945 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Suitland Md.

18. Funeral director: Deal Funeral Home
Address: 4812 Ga ave NW. Wash DC.

19. May 8 1945 Josephine M. Schaeffe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 6 1945 at 9:26 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept Med Exam Case 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary occlusion	died suddenly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank J. Bouchart M.D.
Dep. Med. Exam. M. D. or other
Address: Gaithersburg Md. Date signed: 5-6-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05153 Reg. Dist. No. 212

1. PLACE OF DEATH:
County Montgomery
City or town Martinsburg (Dickerson RFD)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montg
City or town Martinsburg (Dickerson RFD)
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Harriett A. Duley

3. (b) Social Security Number None

4. Sex F
5. Color or race W
6.(a) Single, married, widowed, or divorced Widow
6.(b) Name of husband or wife John A Duley
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) March 26 - 1861

8. AGE: Years 84 Months 1 Days 16 If less than one day ... hrs. ... min.

9. Birthplace Maystown - Pa (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name John E. Norris
13. Birthplace Maryland

MOTHER
14. Maiden name Charlott Tingstin
15. Birthplace Maryland

16. Informant Mrs John Stone
Address Dickerson, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/17/45 (month) (day) (year)
Cemetery or crematory Monocacy
Location Beallsville, MD

18. Funeral director William B. Hilton
Address Barnesville, Md

19. May 12 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 - 1945, at 2:03 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 10 - 1945, to May 12 - 1945
and that I last saw her alive on May 11 - 1945

	DURATION
Immediate cause of death Endarteritis Obliterans	2 yrs.
Due to arteriosclerosis	10 yrs.
Due to	
Other conditions	

(include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE B. D. White, MD. M. D. or other
Address Poolesville, Md Date signed 5/12/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 40e f

CERTIFICATE OF DEATH

Reg. Diat. No. 05154 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 yrs.

Hospital, Institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Bethesda, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 8202 Wis. Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary Elizabeth Durgan

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Willard Ford

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 15, 1894

8. AGE:

Years	Months	Days	If less than one day
50	8	28	..... hrs. ..... min.

9. Birthplace E. Syracuse, Onondaga, New York (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Valentine Roder

13. Birthplace Rochester, New York

MOTHER 14. Maiden name Ella Weydon

15. Birthplace E. Syracuse, New York

18. Informant Mr. Willard Durgan

Address 8202 Wis. Ave. Bethesda, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 14, 1945 (month) (day) (year)

Cemetery or crematory Assumption Cemetery

Location Syracuse, New York

18. Funeral director Wm. Rawlings Sumpheray

Address Bethesda, Maryland

19. 5/14 1945 Wm E Jones (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1945, at 500 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1942 to May 13 1945

and that I last saw h[illegible] alive on May 13 1945

Immediate cause of death Pneumonia — DURATION 3 days

Due to Carcinoma of Uterus & Colon

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. L. Comm M.D. M. D. or other

Address 4016 Langdon Rd Date signed 5/14/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (34)

CERTIFICATE OF DEATH

05155

Reg. Dist. No. 211

1. PLACE OF DEATH:
County: Montgomery
City or town: Near Damascus
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Years
Hospital, institution, or street address where death occurred:
R. F. D. # 5; Mount Airy
How long in hospital or institution? At boarding place

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Near Damascus
(If outside city or town limits, write RURAL and give nearest town)
Street No. R. F. D. # 5; Mount Airy, Md.
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: William Jackson Duvall

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: none

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 29 July 1873

8. AGE: Years 71 | Months 9 | Days 25 | If less than one day: hrs. min.

9. Birthplace: Montgomery County, Maryland.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Farm

FATHER
12. Name: William Jackson Duvall
13. Birthplace: Montgomery County, Maryland

MOTHER
14. Maiden name: Amanda Sprigg
15. Birthplace: West Virginia

16. Informant: Mont Duvall
Address: Gaithersburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 30 1945 (month) (day) (year)
Cemetery or crematory: Damascus Md
Location: Montgomery Co Md

18. Funeral director: Roy W. Barber
Address: Laytonsville Md

19. May 30 1945 (Date rec'd by registrar) Della M. Burdette Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 27, 1945, 12 noon

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1942 to May 27, 1945 and that I last saw him alive on May 13, 1945

Immediate cause of death	DURATION
Hypertensive heart disease	5 years?
Due to: Hypertension	5 years?
Due to: Hypertrophy of the Prostate Gland with partial obstruction	2½ years
Due to: Chronic Uremia (Nov. 1942)	2½ years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No evidence. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: M. McKendree Boyer M.D.
M. McKendree Boyer, M.D. Coroner
Address: Damascus, Maryland Date signed: May 27, 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of age & year of birth of deceased is shown on FILM No. G 95 JUN 5 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05156 Reg. Diat. No. 213

1. PLACE OF DEATH:
County: Montgomery
City or town: Rockville rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Mar. Montrose
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Rockville Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Mar. Montrose
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME EVA ANN EASTERBROOK.

3.(b) Social Security Number — —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed.

6.(b) Name of husband ~~or wife~~: Wm T.
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May - 11 - 1856. 1860

8. AGE: Years	Months	Days	If less than one day
84 85	11	21	hrs. min.

9. Birthplace: New York. (Town, county, and state)
10. Usual occupation: Retired Housewife.
11. Industry or business

FATHER
12. Name: Hendry Benedict
13. Birthplace: N. Y.

MOTHER
14. Maiden name: Rebecca Perkins
15. Birthplace: N. Y.

16. Informant: A. Dunbar Brooks.
Address: 87 Rodney St. Glen Rock. N.J.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May - 4 - 1945 (month) (day) (year)
Cemetery or crematory: Rockville Union
Location: Rockville - Md.

18. Funeral director: Warner & Pumphrey.
Address: 8434 Ga Ave. Silver Spring. Md.

19. 5/3/45 (Date rec'd by registrar) Josephine D. Hatton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 2 1945 at 2.30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1944 to May 2 1945 and that I last saw her alive on May 1 1945.

	DURATION
Immediate cause of death: Coronary occlusion	18 hrs.
Due to: Arteriosclerosis &	5 years
Due to: Senility.	
Other conditions: Fracture neck of left femur - Accidental fall.	7 mos.
(Include pregnancy within 3 months of death)	

Major findings of operations: Reduction & pin, fracture femur Oct. 1944.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Accident. Date of: Oct. 4th 1944.
Where did injury occur? near Rockville (City or town) Montgomery (County) Maryland (State)
Injured at home, farm, industry, public place (where?): in her home, in her bedroom.
Means of injury: Accidental fall. Injured at work?

23. SIGNATURE: Wm. P. Faulkner, M.D. M. D. or other
Address: Rockville, Md. Date signed: 5/2/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

T

05157

Reg. Diat. No. 723

1. PLACE OF DEATH:
County 1000 Carroll Av. Montgomery
City or town Tak. Pk. Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Montgomery
City or town Tak. Pk. Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1000 Carroll Av.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Nannie Amelia Edstrom

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife --

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 5- 1863

8. AGE: Years 81 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Stockholm, Sweden
(Town, county, and state)

10. Usual occupation Housekeeper

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Sweden

MOTHER
14. Maiden name Unknown
15. Birthplace Sweden

16. Informant Mrs E. ~~Trumbull~~ TURNBULL (Friend
Address 1000 Carroll Av., Tak.Pk.Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof 5/14/45 (month) (day) (year)

Cemetery or crematory
Location Washington D C

18. Funeral director The S. H. Hines Co
Address 2901- 14 st N.W.

19. May 14 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14, 1945, at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 43 to May 14 1945 and that I last saw her alive on May 8, 1945

Immediate cause of death Cardio-Vascular Renal Disease — DURATION Several yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings at operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Lynwood Hedges M.D.
M. D. or other

Address 6940 Piney Br. Rd. Tak. Pk. Md. Date signed 5/14/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

05158 223

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, institution, or street address where death occurred:
Washington Sanitarium
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 22- Columbia Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Albert M. Eshelman

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Emily N.
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 13, 1877

8. AGE:

Years	Months	Days	If less than one day
67			hrs. min.

9. Birthplace: Reading Pa. (Town, county, and state)
10. Usual occupation: Book Binder
11. Industry or business: Retired

FATHER
12. Name: Reuben Eshelman
13. Birthplace: Pa.

MOTHER
14. Maiden name: Mary Ann Moyer
15. Birthplace: Pa.

16. Informant: Ester E. Casassa
Address: Niece

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 10 - 45 (month) (day) (year)
Cemetery or crematory: Fort Lincoln Cemetery
Location: Prince George County Md
18. Funeral director: The S. A. Weiss Co
Address: 901-14-st N.W. Washington D.C.
19. May 8 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 8, 1945, at 7:8 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1, 1944, to May 8, 1945, and that I last saw him alive on May 7, 1945

	DURATION
Immediate cause of death: Congestive Heart Failure	Sudden
Due to: Arterio-sclerosis	5 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. Shelley MD M. D. or other
Address: 6911 5th St. N.W. Wash. D.C. Date signed: May 8/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (42)

CERTIFICATE OF DEATH

05159

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Monty

City or town: Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 hrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: St Marys

City or town: Valley Lee

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: Col. U.S. Marine C. ✓

3. (a) FULL NAME: William Garland Fay

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Beatrice Lowe Fay

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1879

8. AGE: Years: 66 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Cumberland Md (Town, county, and state)

10. Usual occupation: Retired Col. U.S.M.C.

11. Industry or business: Marine Corps

FATHER

12. Name: William Wirt Fay

13. Birthplace: Poughkeepsie NY

MOTHER

14. Maiden name: Julia

15. Birthplace: Newport R I

16. Informant: Comd B.A. Griffith USN

Address: 115 Tyler Pl Alex Va

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 9 - 1945 (month) (day) (year)

Cemetery or crematory: Colorado Springs Col.

Location:

18. Funeral director: The S.H. Sines Co

Address: 2901 - 14th St NW

19. May 7 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 7 19 45 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 19 to 19

and that I last saw h alive on 19

	DURATION
Immediate cause of death: coronary occlusion	about
Due to:	and abt day
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank J. Brockhart M.D. M. D. or other

Address: Hagerstown Md Date signed 5-7-45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

T

05160

Reg. Dist. No. 214

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

~~Hospital, Institution, or~~ street address where death occurred:
9713 Fairway Ave.

How long in hospital or institution? X

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. 9713 Fairway Ave
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: MAURICE H. FOLEY

3.(b) Social Security Number: X

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of ~~husband or~~ wife: Mary Hannon

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 1st. 1885

8. AGE: Years	Months	Days	If less than one day
59	8	27	..... hrs. ..... min.

9. Birthplace: Bristol, Conn.
(Town, county, and state)

10. Usual occupation: Realtor

11. Industry or business

FATHER 12. Name: Maurice H. Foley

FATHER 13. Birthplace: Conn.

MOTHER 14. Maiden name: Katherine Jordan

MOTHER 15. Birthplace: Ireland

16. Informant: Mrs. Mary Hannon Foley

Address: 9713 Fairway Ave. Silver Spg.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 5/29/45 (month) (day) (year)

Cemetery ~~or crematory~~: Unknown

Location: Bristol, Conn.

19. Funeral director: Warner E. Pumphrey

Address: 8434 Ga. Ave. Silver Spring, Md.

19. May 28 1945 (Date rec'd by registrar) Josephine McSchaffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 28 1945, at 4:00 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept. 1st. 1944 to ..... 19..... and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	died suddenly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Frank J. Bronchart M.D. M. D. or other

Address: [illegible] Date signed: 5-28-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (72-B)

CERTIFICATE OF DEATH

Reg. Dist. No. 2762 — 05461

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: MONTGOMERY
City or town: TAKOMA PARK
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 11 CLEVELAND AVE.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: MONTGOMERY
City or town: TAKOMA PARK
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 11 CLEVELAND AVE.
(If rural, give LOCATION)
2.(a) 11 veteran, name war

3.(a) FULL NAME: ANNA FOSSUM

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Divorced.

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): SEPT. 2, 1891.

8. AGE: Years	Months	Days	If less than one day
53.	9	—	..... hrs. ..... min.

9. Birthplace: Sweeden. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home

FATHER
12. Name: PETER ERICKSON
13. Birthplace: SWEEDEN

MOTHER
14. Maiden name: INGRID LUNDHOLM
15. Birthplace: SWEEDEN

16. Informant: MRS. LILLIAN E PALMER
Address: 11 CLEVELAND AVE, TAKOMA PARK, MD.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof MAY 6, 1945. (month) (day) (year)
Cemetery or crematory: Mission Church Cemetery.
Location: BRAHAM, MINN.

18. Funeral director: J. Arthur Sellers
Address: 254 Carroll St. Takoma Park D.C.

19. MAY 3 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 2, 1945, at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 27, 1945, to May 2, 1945
and that I last saw h. alive on May 2, 1945

Immediate cause of death	DURATION
Congestive Heart Failure	1 day
Due to: Mitral regurgitation	Indefinite
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: 6711 S. 16th St. Arl. Va. Date signed May 2/45
Washington, D.C.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

T 05162

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
U.S.Naval Medical Center (grounds)

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1831 Corcoran St., N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: FOWLER, Wallace Clarence

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Mary Fowler

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 12-16-97

8. AGE: Years	Months	Days	If less than one day
47	4	12	hrs. min.

9. Birthplace: Greenwood, Mass.
(Town, county, and state)

10. Usual occupation: laborer

11. Industry or business: Consolidated Eng. Co.

FATHER
12. Name: Eddy Fowler
13. Birthplace: N.C.

MOTHER
14. Maiden name: Janie Ray
15. Birthplace: Miss.

16. Informant: T. W. Goodrich
Address: 1318 Bolton St., Baltimore, Md.

17. removal (Burial, cremation, or removal. Which?) Date thereof 5-18-45 (month) (day) (year)

Cemetery or crematory:

Location: Miss.

18. Funeral director: W. Ernest Jarvis J.E.J.
Address: 1432 U Street, N. W.

19. 5-18 1945 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 18 May 19 45, at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep. Med. Exam. 19 to Case 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary occlusion	died suddenly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: injured at work?

23. SIGNATURE: Frank J. Brockhaus M.D. M. D. or other
Dep. Med. Exam.

Address: Gaithersburg Md Date signed 5-18-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for change of age is shown on

FILM No. G 96 JUN 21 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

705163

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No. 602 E Woodbine St
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mary Helen Galbraith

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	Widowed

6.(b) Name of husband or wife Wm John Galbraith
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Dec 12 1859

8. AGE:

Years	Months	Days	If less than one day
86 85			..... hrs. ..... min.

9. Birthplace New Vienna Ohio (Town, county, and state)
10. Usual occupation Home - maker
11. Industry or business

FATHER
12. Name James Liddle
13. Birthplace Scotland

MOTHER
14. Maiden name Mary Abbotts
15. Birthplace Scotland

16. Informant Wm Howard Galbraith
Address 3408-10 14th St NE

17. Removal (Burial, cremation, or removal. Which?) Date thereof 5-31-45 (month) (day) (year)
Cemetery or crematory
Location
18. Funeral director L H Harris Co
Address 2901-14th St NW

19. 5-31-45 (Date rec'd by registrar) 19..... Registrar W E Jobes.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1945, at 8:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 25 1945 to May 30 1945 and that I last saw her alive on May 30 1945

Immediate cause of death	DURATION
(a) acute Cardiac Dilatation	3 Days
Due to Arterio Sclerosis & Mitral heart disease.	
Due to (b) Cardio Vascular Renal Disease	10 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings at operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H C Hatter MD (M.D. or other)
Address 1122 Monroe St NE Date signed May 30/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05164

Reg. Dist. No. 213.

1. PLACE OF DEATH:
County: Montgomery
City or town: Lincoln Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant give residence of mother)
State: Maryland County: Montgomery
City or town: Lincoln Park
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rockville, Md.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Lillie George

3. (b) Social Security Number

4. Sex: Female
5. Color or race: Colored
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: Frank George
6.(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): December 10, 1905
8. AGE: Years: 39 Months: 6 mo Days: 10 If less than one day: hrs. min.
9. Birthplace: Atlanta Georgia (Town, county, and state)
10. Usual occupation:
11. Industry or business: House keeper
FATHER 12. Name: Willis Isreal
FATHER 13. Birthplace: Atlanta, Georgia
MOTHER 14. Maiden name: Alice Hamell
MOTHER 15. Birthplace: Wilkes Co. Georgia
16. Informant: Mrs. Lillian Cook (Sister)
Address: Rockville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 20, 1945 (month) (day) (year)
Cemetery or crematory: Lincoln Park Cem.
Location: Rockville, Maryland
18. Funeral director: R. L. Snowden
Address: 246 N. Washington St Rockville, Md
19. 5/20/45 Joseph D. Hatton Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 17 1945 at 4 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1944 to May 17 1945
and that I last saw h.e alive on May 15 1945

	DURATION
Immediate cause of death: Carcinoma of uterus cervix genitalia, metastasis.	3½ yrs
Due to:	
Due to:	
Other conditions: none.	

(Include pregnancy within 3 months of death)

Major findings of operations: Radium - 1942 Date of op.
Autopsy results: none.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wm. A. Faulkner M.D.
M. D. or other
Address: Rockville, Md. Date signed 5/17/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (160)

CERTIFICATE OF DEATH

05165 Reg. Dist. No. 423

1. PLACE OF DEATH:

County: MONTGOMERY

City or town: TAKOMA PARK

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, ~~institution, or street~~ address where death occurred:

WASHINGTON SANITARIUM & HOSPITAL

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring - Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 822 Sligo Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME: Infant Boy Griffith

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): MAY 16 - 1945

8. AGE: Years	Months	Days	If less than one day
0	0	0	1 hrs. ..... min.

9. Birthplace: TAKOMA PARK - MD (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name: PAUL EUGENE GRIFFITH

13. Birthplace: WALTHILL - NEB

MOTHER

14. Maiden name: GENEVIVE M. BROWN

15. Birthplace: SPENCER - IOWA

16. Informant: PAUL - E - GRIFFITH

Address: 822 - SLIGO AVE. SILVER SPRING -

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: MAY 18 1945 (month) (day) (year)

Cemetery or ~~crematory~~: GEORGE WASHINGTON MEMORIAL

Location: RIGGS RD. PR. GEORGES CO. MD

18. Funeral director: Warner E Pumphrey

Address: 8430 Ga Ave - Silver Spring - md.

19. MAY 16 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5-16-45 19..... at 11.40 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10.37 Pm 5-16-45 19..... to 11.40 Pm 5-16-45 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death: Asphyxia Neonatorum — DURATION: 1 hr

Due to: Hyp. Caesarian section

Due to:

Due to:

Other conditions:

(Incinde pregnancy within 3 months of death)

Major findings of operation:

Date of op.:

Autopsy results: Asphyxia Neonatorum

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Kenneth Laughlin M.D. (M. D. or other)

Address: 8252 Ga Ave Date signed: 5-16-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9)

05166

CERTIFICATE OF DEATH

Reg. Dist. No. 212

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Montgomery
City or town Boyd. R.F.D. (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md County Montg
City or town Boyd. R.F.D. (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Nancy Lee Grove

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife None
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 15 - 1944

8. AGE: Years	Months	Days	If less than one day
	7	5	..... hrs. ..... min.

9. Birthplace Bethesda, Md, Montg, Co (Town, county, and state)
10. Usual occupation None
11. Industry or business

FATHER
12. Name Layman Groves
13. Birthplace Virginia

MOTHER
14. Maiden name Mary Burkhart
15. Birthplace Maryland

16. Informant Layman Groves
Address Boyd. RFD. Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/24/45 (month) (day) (year)
Cemetery or crematory Tooles Tract
Location Dickerson, Md
18. Funeral director William B. Hilton
Address Barnesville, Md
19. May 21 1945 Mrs. C.C. Hilton By Mrs. W.B.H. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 - 1945 at 1:20 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan. 12 - 1945 to May 20 - 1945 and that I last saw h[illegible] alive on May 20 - 1945

Immediate cause of death	DURATION
Broncho pneumonia	2 days.
Due to Pertussis	10 days.
Due to Premature baby (7 mos)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE B. D. White M.D. M. D. or other
Address Barnesville, Md. Date signed 5/24/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (22)

CERTIFICATE OF DEATH

T

05167

Reg. Dist. No. 214

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 1/2 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 42 Sycamore Ave

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME William Gunther

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Juliana Gunther

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 15, 1853

8. AGE: Years: 92 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: Farmer (Retired)

11. Industry or business

FATHER 12. Name: Unknown

13. Birthplace

MOTHER 14. Maiden name: Unknown

15. Birthplace

16. Informant: Frank E. Gunther

Address: 42 Sycamore Ave.

17. Burial, cremation, or removal. Which?: Removal Date thereof: May 1 1945 (month) (day) (year)

Cemetery or crematory: Baltimore Md.

Location: Washington D.C.

18. Funeral director: James E. Ryan

Address: 617 Pa. Ave. S.E.

19. May 1 1945 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5/1/45 at 7.55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/28/44 to 5/1/45 and that I last saw h... alive on 4/27/45

Immediate cause of death	DURATION
Bronchopneumonia	2 days.
Due to: Coronary Arteriosclerosis.	?
Due to: Old Age - Myocarditis	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Howard T. Brown M.D. M.D. or other

Address: 28 Carroll Ave Takoma Park Md. Date signed: 5/1/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


R.F.A.
MAY 14 1945
BUREAU V.S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

05168

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170-e

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

1. PLACE OF DEATH:

County Montgomery Co

City or town Takoma Park, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5-13-45 ; 5-14-45

Hospital, institution, or street address where death occurred:
Washington San. & Hosp.

How long in hospital or institution? 5-13-45 ; 5-14-45

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Montgomery

City or town Silver Springs
(If outside city or town limits, write RURAL and give nearest town)

Street No. Box # 83
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME
Harkins, Mr. Howard.

3. (b) Social Security Number

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married.

6. (b) Name of husband or wife Harkins, Mrs Hattie-

6. (c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) April 1, 1900

8. AGE:

Years	Months	Days	If less than one day
45	1	13	... hrs. ... min.

9. Birthplace Pennsylvania
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business George Wash. Mem. Cemetery-

FATHER
12. Name William Harkins
13. Birthplace Frogtown Penn-

MOTHER
14. Maiden name Clare Springer
15. Birthplace — Pennsylvania

16. Informant Washington Sanitarium Records

Address Takoma Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-16-45 (month) (day) (year)

Cemetery or crematory Union Cemetery

Location Burtonsville, Md.

18. Funeral director [illegible] Co.

Address [illegible] Md

19. 5/14 1945 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1945, at 9:28 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... , to ... 19...

and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death Autopsy Washington Sanitarium & Hospital	
Due to Rupture dura intra cranial	2 days
Due to Hemorrhage	
Other conditions [illegible]	

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op.

Autopsy results [illegible]

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ? Acc. Date of ? 5/13/45

Where did injury occur? ? Montg. Md
(City or town) (County) (State)

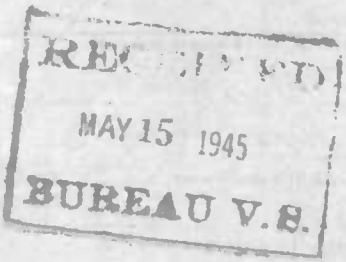
Injured at home, farm, industry, public place (where?) public place

Means of injury Hit by automobile? Injured at work?

23. SIGNATURE [illegible] [illegible] Pathologist
M. D. or other

Address [illegible] Spring Md Date signed 5/14/45

Inf. re. accident from report from Comm. of M.V. 6/30/45 -
ds.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

T05169 218

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Montgomery
City or town Gaithersville Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 Years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Gaithersville Rural R F D
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Samuel Hawkins

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	Widower

6.(b) Name of husband or wife Ethel Prather Hawkins
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 28 - 1893

8. AGE: Years	Months	Days	If less than one day
52	0	2	hrs. min.

9. Birthplace Montgomery Co Md (Town, county, and state)
10. Usual occupation Laborer on Farm
11. Industry or business Farm
FATHER 12. Name Richard Hawkins
13. Birthplace Montgomery Co Md
MOTHER 14. Maiden name Ella Kingstuart
15. Birthplace Montgomery Co Md
16. Informant James Hawkins
Address Gaithersburg Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 2 1945 (month) (day) (year)
Cemetery or crematory Brookside Gdns Md
Location Gaithersburg Md
18. Funeral director Roy W Barber
Address Gaithersburg Md
19. 6/4/45 (Date rec'd by registrar) L. R. Bell Asst. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1945, at 11 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 25 1945, to May 30 1945
and that I last saw him alive on May 29 1945

Immediate cause of death	DURATION
Pulmonary Hemorrhage	
Due to Pulmonary Tuberculosis	Unknown
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings at operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Vernon H Dyson M. D. or other
Address Laytonsville Md Date signed June 7 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

Reg. Dist. No. 05130 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months & 28 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 2 months & 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Arizona County:

City or town: Wilcox
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: HEUSSER, Charlie Norman, Cpl. USMC

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 5 July 1918

8. AGE: Years	Months	Days	If less than one day
26	10	18	hrs. min.

9. Birthplace: Calif.
(Town, county, and state)

10. Usual occupation: Marine Corps

11. Industry or business:

FATHER
12. Name: Edmund Heusser
13. Birthplace: Switzerland

MOTHER
14. Maiden name: Mary E Orr
15. Birthplace: ?

16. Informant: Mother: Mrs. Mary C. Church

Address: Wilcox, Arizona

17. burial (Burial, cremation, or removal. Which?) Date thereof 5-26-45 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: W. W. CHAMBERS W A MacLea

Address: 1400 Chapin St., N. W. Wash., D. C.

19. 5-23- 19 45 (Date rec'd by registrar) mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 23 May 19 45 at 1:25a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 22 May 19 45 to 23 May 19 45 and that I last saw him alive on 23 May 19 45

Immediate cause of death	DURATION
Pneumonia, Bilateral,	9 days
Broncho	
Due to: Bronchiectasis, Bilateral	unknown
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Bilateral Bronchiectasis, Badly infected Date of op. 11 May 1945

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. L. Ebb M. D. or other

Address: USNH, Bethesda, Md. Date signed: May 23, 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (167)

CERTIFICATE OF DEATH

Reg. Dist. No. 1517 216

T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Monty T Bethesda P.O.

City or town: Rockville outside

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 hrs.

Hospital, institution, or street address where death occurred:

Sanatorium Hosp

How long in hospital or institution? 3 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Monty

City or town: Rockville

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Helen Hoskins

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 7, 1911

8. AGE: Years: 34 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Aspen Hill, Md. (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business:

FATHER 12. Name: James Davis

13. Birthplace: Montgomery County

MOTHER 14. Maiden name: Bessie Wise

15. Birthplace: Md.

16. Informant: Junnium C. Davis (Bro).

Address: Washington D. C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-6-45 (month) (day) (year)

Cemetery or crematory: Lincoln Park

Location: Rockville, Md.

18. Funeral director: R. L. Snowden

Address: 246 N. Wash St. Rockville Md.

19. 5/6 (Date rec'd by registrar) 1945 Wm E Jordan Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 2 1945, at 11:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dept Med. Exam 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Shock - Hemorrhage	
Due to Compound fracture of skull (Homicide)	4 hrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: homicide Date of 5-2-45

Where did injury occur? Rockville R 7 S. Monty Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): home

Means of injury: struck with ax Injured at work?

23. SIGNATURE: Frank J. Broschart M.D.

Gaithersburg Md M. D. or other

Address: Dept Med Exam Date signed 5-3-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

T 05172

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Chevy Chase, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
4862 Chevy Chase Blvd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4862 Chevy Chase Blvd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

ARCTURUS LEE HOWARD

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: ~~Elizabeth~~ Anna M. Howard

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1870

8. AGE: Years	Months	Days	If less than one day
75			hrs. min.

9. Birthplace: DC
(Town, county, and state)

10. Usual occupation: M D

11. Industry or business

FATHER 12. Name: Joseph T Howard

13. Birthplace: Va

MOTHER 14. Maiden name: Elizabeth Donaldson

15. Birthplace: NJ

16. Informant: Ruth Howard Harper

Address: 4862 C. Chase Blvd

17. Removal (Burial, cremation, or removal. Which?) Date thereof 5-31-45 (month) (day) (year)

Cemetery or crematory

Location: L H Hines Co

18. Funeral director

Address: 2901-14th St NW

19. 5-31-45 (Date rec'd by registrar) 19 WE Jobes. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 31 19 45, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 7, 1929 19 to May 31 19 45 and that I last saw him alive on May 30 19 45

Immediate cause of death	DURATION
Uremia	4 days
Cerebral hemorrhage	1 month
Due to cardio-vascular renal disease	undetermined.
Prostatic hypertrophy	
Due to arteriosclerosis involving heart and kidney	undetermined.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Stephen P. King M. D. or other

Address: 1835 Eye St. N. W. Date signed: 5/31/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

CERTIFICATE OF DEATH

5173

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 days

Hospital, institution, or street address where death occurred:

USNH, Bethesda, Maryland

How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Va. County:

City or town: Fairlington

(If outside city or town limits, write RURAL and give nearest town)

Street No. Apt. A-1, 2916 Buchanan St.,

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: HOWATT, Mabel Ruth

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 12 March 1866

8. AGE: Years	Months	Days	If less than one day
79	2	0	hrs. min.

9. Birthplace: Va (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Dudley Ruthe

13. Birthplace: Ohio

MOTHER — 14. Maiden name: Sarah Gassiway

15. Birthplace: Va.

16. Informant: Son: Mr. Irving M. Cooke

Address: 2916 Buchanan St., Fairlington, Va. Apt. A-1

17. removal (Burial, cremation, or removal. Which?) Date thereof: 5-13-45 (month) (day) (year)

Cemetery or crematory:

Location: Brooklyn, N.Y.

18. Funeral director: W. W. Chambers

Address: 1400 Chapin St., N. W., Wash., D.C.

19. 13 May 1945 Mary Charlotte Smith

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12 May 1945 at 7:25a M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 30 April 1945 to 12 May 1945

and that I last saw her alive on 12 May 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage	1 Month
Due to: Hypertension	5 years
Due to: Arteriosclerosis	10 years
Other conditions: Auricular Fibrillation	unknown

(Include pregnancy within 3 months of death)

Major findings of operations: No Operation Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Gordon R Lamb M. D. or other

Address: USNH Bethesda, Md. Date signed: 5-13-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18-E)

CERTIFICATE OF DEATH

T

05174

Reg. Dist. No. 212

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Montgomery
City or town: Boyds, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Monty
City or town: Boyds
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Charles E. Hoyer

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	married

8.(b) Name of husband or wife: Mary J. Hoyer
8.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): June 30 1880

8. AGE:

Years	Months	Days	If less than one day
64	10	2	hrs. min.

9. Birthplace: Frederick co. Md
(Town, county, and state)
10. Usual occupation: laborer
11. Industry or business: —

FATHER
12. Name: Charles Lewis
13. Birthplace: West VC

MOTHER
14. Maiden name: Mary Hoyer
15. Birthplace: Md

16. Informant: Mary Hoyer
Address: Blyds Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof: May 5, 1945 (month) (day) (year)
Cemetery or crematory: County Home
Location: Rockville, Maryland
18. Funeral director: Robert L. Snouden
Address: Rockville, Maryland

19. May 4 1945 (Date rec'd by registrar) Mrs. C. C. Hilton Registrar
By Mrs. Hilton

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 2 19 45, at 4:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. Med. Exam 19 to Case 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Acute Myocarditis	½ day
Due to: Chronic Nephritis	x yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Frank J. Bouchut M.D.
Sept. Med. Exam M. D. or other
Address: Clarksburg, Md. Date signed: 5-3-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05175

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 days
Hospital, institution, or street address where death occurred: USNH, Bethesda, Maryland
How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Cambridge
(If outside city or town limits, write RURAL and give nearest town)
Street No. 18 Fairmount Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: V

3.(a) FULL NAME: HUGHES, Milton (n), VBP

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Maude S. Hughes
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 15, 1893

8. AGE: Years	Months	Days	If less than one day
51	10	19	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Retail Merchant
11. Industry or business

FATHER
12. Name: Edward Hughes
13. Birthplace: Maryland

MOTHER
14. Maiden name: Annia E. Cromwell
15. Birthplace: Maryland

16. Informant: Wife: Mrs. Maude S. Hughes
Address: 18 Fairmount Ave., Cambridge, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 5-8-45 (month) (day) (year)
Cemetery or crematory: Waugh Cemetery
Location: Cambridge, Maryland
18. Funeral director: H. M. St. Clare & Son
Address: Cambridge, Md.

19. 5-5-45 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4 May 1945, at 7:07P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 23 April 1945, to 4 May 1945
and that I last saw him alive on 4 May 1945

Immediate cause of death	DURATION
Carcinoma Bronchus (left)	unknown
Due to: Myocarditis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma, Bronchus
Date of op. 4 May 1945
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: E. M. Kent
E. M. KENT, Lt. Condr. (MC) USNR
M. D. or other
Address: USNH, Bethesda, Md. Date signed: 5-5-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05176

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda, (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 hours
Hospital, institution, or street address where death occurred:
U S Naval Hospital, Bethesda, Md.
How long in hospital or institution? 5 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Va. County:
City or town: Arlington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1100 Kennebeck St.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: HUGHES, William Robert, 2nd Lt. USMC

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Marjorie Hughes
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 12-24-95

8. AGE: Years	Months	Days	If less than one day
49	4	24	hrs. min.

9. Birthplace: Wisconsin
(Town, county, and state)

10. Usual occupation: USMarine Corps

11. Industry or business:

FATHER
12. Name: Robert L. Hughes
13. Birthplace: Wis. (deceased)

MOTHER
14. Maiden name: Harriet Cator
15. Birthplace: Wis.

16. Informant: Wife: Mrs. Marjorie Hughes
Address: 1100 Kennebeck St., Arlington, Va.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 5-21-45 (month) (day) (year)

Cemetery or crematory: Arlington National
Location: Arlington, Va.

18. Funeral director: W. W. Chambers, - R.F.
Address: Georgetown, Washington, D. C.

19. 5-18-45 (Date rec'd by registrar) mx Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 18 MAY 1945, at 1 35 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 17 MAY 1945, to 18 MAY 1945
and that I last saw h. im alive on 18 MAY 1945

	DURATION
Immediate cause of death: HEMORRHAGE CEREBRAL	5 HOURS
Due to: HYPERTENSION	1 YEAR
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Alyzia B Hayles M. D. or other
Address: USNHosp Bethesda Md. Date signed: 5.18.45

(M) MARGIN RESERVED FOR BINDING (I) (T)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

BC

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

15177

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? one month, 21 days

Hospital, institution, or street address where death occurred:

US NAVAL Hospital, Bethesda, Md.

How long in hospital or institution? one month, 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 2631 Fait Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: KAPELANCZYK, Frank Joseph, CMoMM USN Ret. Inactive

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 27 Nov. 1898

8. AGE: Years: 46 | Months: 6 | Days: 15 | If less than one day: hrs. min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: retired

11. Industry or business:

FATHER — 12. Name: Joseph (n) Kapelanczyk

FATHER — 13. Birthplace: Poland

MOTHER — 14. Maiden name: Lillie Kopczynski

MOTHER — 15. Birthplace: Md.

16. Informant: Father: Mr. Joseph Kapelanczyk

Address: 2631 Fait Avenue, Baltimore, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof May 16 1945 (month) (day) (year)

Cemetery or crematory: Holy Rosary Cemetery

Location: Baltimore, Md.

18. Funeral director: John M. Heber

Address: Chester & Bank St., Baltimore, Md.

19. 5-12 (Date rec'd by registrar) 19 45 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12 May 19 45, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 21 March 19 45, to May 12 19 45 and that I last saw h im alive on 11 May 19 45

Immediate cause of death	DURATION
Miliary Tuberculosis	3 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: C. E. Smith M. D. or other

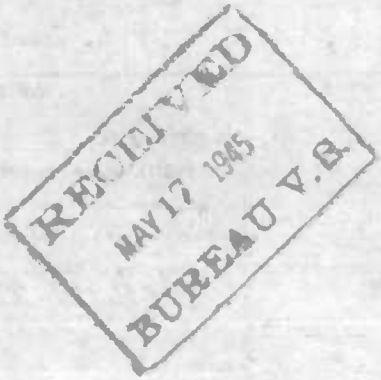
Address: USNH. Bethesda Md. Date signed: 5-12-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Rec'd 4/15/45 MB


RECEIVED
MAY 17 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

#5178

Reg. Dist. No. 214

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring (outside)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Killed instantly

Hospital, institution, or street address where death occurred: —

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Pa. County: York

City or town: York
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1108 N. George St.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War II ✓

3. (a) FULL NAME: Pvt. William J. Knaub

3. (b) Social Security Number: 1923 4273

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 8, 1926

8. AGE: Years	Months	Days	If less than one day
19	2	18	..... hrs. ..... min.

9. Birthplace: York Pa (Town, county, and state)

10. Usual occupation: Student

11. Industry or business

FATHER — 12. Name: W. Frank Knaub

FATHER — 13. Birthplace: Cross Roads township York, Pa

MOTHER — 14. Maiden name: Ida Belle Stern

MOTHER — 15. Birthplace: Newberry township York Pa

16. Informant

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof May 29 1945 (month) (day) (year)

Cemetery or crematory

Location: York Pa.

18. Funeral director: Wantler Funeral Home

Address: 301 E. Capital St. Wash. D.C.

19. May 28 1945 (Date rec'd by registrar) Josephine M Schaffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 26 19 45, at 1:25 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. med. Exam 19 ..... to ..... 19 .....

and that I last saw h..... alive on ..... 19 .....

	DURATION
Immediate cause of death: Compound fracture of skull with multiple body and	died instantly
Due to: extremity injuries	
Due to: aeroplane accident	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Accidental Date of 5-26-45

Where did injury occur? Silver Spring (City or town) Monty (County) md (State)

Injured at home, farm, industry, public place (where?): air

Means of injury: aeroplane Injured at work? yes

23. SIGNATURE: Frank J. Bracken M. D. (M. D. or other)

Address: Dept. Med. Exam. Baltimore md Date signed: 5-27-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

27 May 1945

Released to US Army Authorities, Washington, DC

Frank J. Broschart

FRANK J BROSCHART, MD
Deputy Medical Examiner
for Montgomery County, Md

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

05179

Reg. Diat. No. 716

1. PLACE OF DEATH:

County: Monty

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mo.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Ohio County:

City or town: Cleveland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2552 Fairmount Blvd.

(If rural, give LOCATION)

2.(a) If veteran, name war: World war # II ✓

3.(a) FULL NAME Lt. col. James L. Luke

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Mar. 30 1905

8. AGE: Years	Months	Days	If less than one day
40	1	20	..... hrs. ..... min.

9. Birthplace: W. Va.
(Town, county, and state)

10. Usual occupation: Army air corps - U.S.A.

11. Industry or business

FATHER 12. Name: David L. Luke

13. Birthplace: Rockland, Md

MOTHER 14. Maiden name: Bessie Anderson

15. Birthplace: Little Wash, Va.

16. Informant: Col. C. P. Prescott

Address: 7210 Exeter st. Bethesda md

17. Removal (Burial, cremation, or removal. Which?) Date thereof May 12/45 (month) (day) (year)

Cemetery or crematory

Location: New York City N. Y.

18. Funeral director: Wastler Funeral Home

Address: 301 E. Capitol St. Wash. D.C.

18. 5/21 19 45 (Date rec'd by registrar) Wm E. Jolley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 20 1945 at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 19 to Date 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Asphyxia due to smoke, heat	
Due to Burns from burning	Hours
1st and 2nd degree burns	2
Due to back arms and face	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accidental Date of 5-20-45

Where did injury occur? Bethesda (City or town) Monty (County) Md (State)

Injured at home, farm, industry, public place (where?) home

Means of injury Injured at work?

23. SIGNATURE: Frank J. Bonstant M.D. M. D. or other

Address: Gaithersburg md Date signed 5-20-45

VS A15

PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


RECEIVED
MAY 24 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

105180

Reg. Dist. No. 212

1. PLACE OF DEATH:

County Montgomery

City or town Boyd R.F.D. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Montg

City or town Boyd, R.F.D. (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Leola F. Larman

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2 - 1945

8. AGE: Years	Months	Days	If less than one day
	2	16	hrs. min.

9. Birthplace Boyd, MontgCo, Md (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Marshall C Larman

13. Birthplace Maryland

MOTHER 14. Maiden name Edna Lee Jarels

15. Birthplace Virginia

16. Informant Marshall C Larman

Address Boyd, R'F D. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/20/45 (month) (day) (year)

Cemetery or crematory Boyd Presbyterian

Location Boyd, Md.

18. Funeral director William B. Hilton

Address Barnesville, Md

19. May 19 1945 (Date rec'd by registrar) Mrs. C. C. Hilton By Mrs. C. C. Hilton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 1945 at 7.50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 16 1945, to May 18 1945

and that I last saw h... alive on May 18 1945

Immediate cause of death	DURATION
Bronchopneumonia	
Due to	
cold.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. Marshall Larman M.D. M. D. or other

Address Barnesville Md Date signed May 19/45.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186a)

CERTIFICATE OF DEATH

T 05181

Reg. Dist. No. 223

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 mos. + 21 days
Hospital, institution, or street address where death occurred:
WASHINGTON SANITARIUM + HOSPITAL
How long in hospital or institution? 7 mos. + 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: District of Columbia County:
City or town: WASHINGTON, D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Wyoming Apt. - WASHINGTON, D.C.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: MARLOWE, MRS. CLARA

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	WIDOWED

6.(b) Name of husband or wife: MR. William Marlowe
Deceased - 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 11, 1875

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
69	11	10		

9. Birthplace: WASHINGTON, D.C.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: MR. Frederick Krackhaudt
13. Birthplace: Germany
MOTHER 14. Maiden name: Minnie Lemke
15. Birthplace: Germany
16. Informant: WASHINGTON SANITARIUM + HOSPITAL Records
Address: Takoma Park, Maryland -
17. Removal (Burial, cremation, or removal. Which?) Date thereof May 21 - 45 (month) (day) (year)
Cemetery or crematory: Washington, D.C.
Location: 2901 - 14th St. N.W. -
18. Funeral director: S.H. Hines Co.
Address: 2901 - 14th St. N.W.
19. May 21 19 45 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 21" - 19 45, at 5:00 P. M.
21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from Oct 30 - 19 44, to May 21, 19 45
and that I last saw her alive on May 21, 19 45

	DURATION
Immediate cause of death: Coronary Occlusion	2 hours
Due to: Fracture mid left femur	67 days
Due to: Accidental Fall - fell out of a deck chair	
Other conditions: Atherosclerosis General.	5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: ✓
Date of op. ✓
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: March 14, 1945
Where did injury occur? On aboard (City or town) — (County) monty Co. (State)
Injured at home, farm, industry, public place (where?): —
Means of injury: Injured at work? —

23. SIGNATURE: Henry S. Browne, M.D.
M. D. or other
Address: Takoma Park, Md. Date signed: 5/21/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30

CERTIFICATE OF DEATH

65182

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery County
City or town: Silver Spring, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring (If outside city or town limits, write RURAL and give nearest town)
Street No. 1502 East-West Highway (If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Frank Martini

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: XXX or Maria Faber Martini
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 24, 1866

8. AGE: Years 78 | Months 5 | Days 10 | If less than one day ..... hrs. ..... min.

9. Birthplace: Potsdam, Germany (Town, county, and state)

10. Usual occupation: Retired Baker

11. Industry or business

FATHER
12. Name: Gustav Martini
13. Birthplace: Germany

MOTHER
14. Maiden name: Elise Rittner
15. Birthplace: Germany

16. Informant: Mrs. Owen L. Scott
Address: 2001 Plymouth St., N.W., Wash., D.C.

17. Washington, D.C. Date thereof: May 4, 1945 (month) (day) (year)
(Local registrar's record of removal, where?)

Cemetery or crematory:
Location:

18. Funeral director: The S. H. Hines Co.
Address: 2901-14th St., N.W., Wash. D.C.

19. 5/4 1945 Mrs E Jobes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 4th 1945, at 9:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1st 1944, to May 4th 1945, and that I last saw h.. alive on May 4th 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 hour
Due to Arteria Sclerosis	10 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: W B Lewis M. D. or other
Address: 1746 - K St 2W Date signed: 5/4/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(F 5183

Reg. Diat. No. 916

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Suburban Hospital
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Glen Echo
(If outside city or town limits, write RURAL and give nearest town)
Street No. 102 University Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs-Marcella Mc Dannell

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female (FEMALE)	White	married

6.(b) Name of husband or wife: Clyde B-
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): unknown 1886

8. AGE: Years	Months	Days	If less than one day
59	-	-	hrs. min.

9. Birthplace: Penn-
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: William Abbott
13. Birthplace: England
MOTHER 14. Maiden name: Sykes
15. Birthplace: England
16. Informant: Clyde B. Mc Dannell
Address: Glen Echo, Md.
17. Shipment (Burial, cremation, or removal. Which?) Date thereof 5/24/45 (month) (day) (year)
Cemetery or crematory: Holy Trinity
Location: Erie Pa.
18. Funeral director: W. Reuben Humphrey
Address: 7557 Wis. Ave. Bethesda
19. 5/23 19 45 Wm E Jokel M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 21, 19 45 at 12 55 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/19/45 19 to 5/21/45 19 and that I last saw her alive on 5/21/45 19

Immediate cause of death	DURATION
ventricular fibrillation	
Due to: mural thrombosis	
Due to:	
Other conditions: myocardial dilatation, Fatty Metamorphosis	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: I L Marbs M. D. or other
Address: 4601 Leland St Date signed: 5/21/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

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988,879
121

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (53)

CERTIFICATE OF DEATH

05184217

Reg. Diat. No. ~~75~~ 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Montgomery

City or town Olney, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital Inc.

How long in hospital or institution? 2 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Howard

City or town Glenwood

(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME James Edward Miles

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored.	

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 25, 1882

8. AGE: Years	Months	Days	If less than one day
63	3	14	hrs. min.

9. Birthplace Glenwood, Howard Co. Md (Town, county, and state)

10. Usual occupation laborer.

11. Industry or business

FATHER 12. Name George Albert Miles

13. Birthplace

MOTHER 14. Maiden name

15. Birthplace

16. Informant Hospital records.

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 11 1945 (month) (day) (year)

Cemetery or crematory Bush Park

Location near Cooksville, Howard Co.

18. Funeral director H. M. Snyder

Address Mt. Airy

19. 5-9-1945 Gertrude K. Lawler (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9 1945, at 1:30 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 7 1945, to May 9 1945, and that I last saw h.. i.m alive on May 9 1945.

	DURATION
Immediate cause of death Hypertensive Heart disease with Hyper-tension	unknown
Due to	
Due to	
Other conditions Elephantiasis	unknown

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas. B. Tomlinson M. D. or other

Address Sandy Spring, Md. Date signed 5/9/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (173)

CERTIFICATE OF DEATH

05185

Reg. Dist. No. 214

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring (Outside)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Fleet Maternity

Hospital, institution, or street address where death occurred: —

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Frederick

City or town: Frederick
(If outside city or town limits, write RURAL and give nearest town)

Street No. 118 E. Patrick St.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War II ✓

3. (a) FULL NAME: S/Sgt. William C. Moberly

3. (b) Social Security Number: 13000564

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: NANCY V.

6.(c) If alive, give age: 28 years

7. Birth date of deceased (mo., day, yr.): 3 May 1917

8. AGE: Years	Months	Days	If less than one day
28	0	23	..... hrs. ..... min.

9. Birthplace: Frederick, Md
(Town, county, and state)

10. Usual occupation: SOLDIER

11. Industry or business

FATHER
12. Name: MERHL F. Moberly
13. Birthplace: Frederick - Md

MOTHER
14. Maiden name: Emma E Zentz
15. Birthplace: Nashville, Ill

16. Informant

Address

17. Cremation (Burial, cremation, or removal. Which?) Date thereof May 28 1945 (Month) (day) (year)

Cemetery or crematory: Lee Crematory

Location: 4th & Mass. ave. N.E. Wash. D.C.

18. Funeral director: Weather Ferneyhough

Address: 301 E. Capitol St. Wash. D.C.

19. May 26 1945 (Date rec'd by registrar) Josephine McSchaffe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 26 1945, at 1:25 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept. Med. Exam Case 19..., to ..... 19.....

and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Compound fracture of skull with multiple body and	died instantly
Due to extremity injuries	
Due to aeroplane accident	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accidental Date of 5-26-45

Where did injury occur? Solomons (City or town) Md. (County) Md. (State)

Injured at home, farm, industry, public place (where?): air

Means of injury: aeroplane Injured at work? yes

23. SIGNATURE: Frank J. Broxhead M.D.
Med. Exam., M. D. or other

Address: Hagerstown Date signed 5-27-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

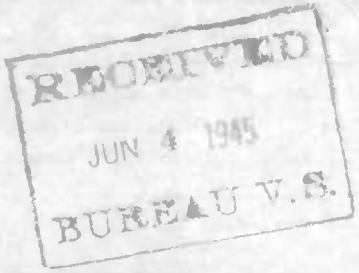
MARGIN RESERVED FOR BINDING

27 May 1945

Released to US Army Authorities, Washington, DC

Frank J Broschart

FRANK J BROSCHART, MD
Deputy Medical Examiner
for Montgomery County, Md



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

05186

Reg. Dist. No. 423

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Montgomery
City or town Takoma Park Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Washington Sanitarium
How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Virginia County
City or town Vienna
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME John Brown Moulton

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife Bertha Moulton
6.(c) If alive, give age 82 years

7. Birth date of deceased (mo., day, yr.) Aug. 12. 1859

8. AGE: Years	Months	Days	If less than one day
85	9	13	hrs. min.

9. Birthplace Randolph. Vermont (Town, county, and state)
10. Usual occupation plumbing and Heating
11. Industry or business
FATHER 12. Name Jude Moulton
FATHER 13. Birthplace Randolph Vermont
MOTHER 14. Maiden name Sarah Balchelder
MOTHER 15. Birthplace Wandgrove, Vermont
16. Informant Sanitarium Records
Address
17. Removal (Burial, cremation, or removal. Which?) Date thereof May 25- 45 (month) (day) (year)
Cemetery or crematory
Location Vienna Va
18. Funeral director Money & King
Address Vienna Va
19. May 25 19 45 J. Wm. Dodd Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 19 45, at 10:40 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1938, to May 25 1945
and that I last saw h.. alive on May 24 1945

	DURATION
Immediate cause of death Coronary Occlusion	Immediate
Due to	
Due to Cerebral Hemorrhage	3 wks
Other conditions Pyelonephritis	1 wks

(Include pregnancy within 3 months of death)

Major findings of operations ✓
Date of op.
Autopsy results ✓
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Robert Abare M.D.
M. D. or other
Address Takoma Park Md. Date signed 5/25/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(5187

Reg. Diat. No. .....

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring No

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, Institution, or street address where death occurred:

828 Wayne ave

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 828 Wayne ave

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME Florence Tucker Myers

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Walter O. Myers

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): April 5, 1869

8. AGE: Years	Months	Days	If less than one day
76	1	9	..... hrs. ..... min.

9. Birthplace: Forest Hill Baltimore Md (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: —

FATHER

12. Name: William David Tucker

13. Birthplace: Md.

MOTHER

14. Maiden name: Sarah A. Cooter Jones

15. Birthplace: Md.

16. Informant: Mrs Harry G. Haden

Address: 830 Bruce ave, Clearwater, Fla.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/17/45 (month) (day) (year)

Cemetery or crematory: Slateville

Location: Delta Pa.

18. Funeral director: William Cook Inc

Address: 1217 St. Paul st

19. 5-16-45 (Date rec'd by registrar) J. W. Kreider Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 14 1945, at 11 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 14 1945, to May 14 1945

and that I last saw h— alive on May 14 1945

Immediate cause of death	DURATION
Bronchial Pneumonia	1 day
Due to	
Due to	
Due to	
Other conditions: Hypertension Heart Disease	?

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. Marion Beardsley M.D. M. D. or other

Address: 9401 Sutton place, Silver Spring, Md. Date signed 5/14/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Dr. F. J. Broschart, County Coroner, notified & he authorized issuance of this certificate by me.

J. Marion Barnhart

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (122-6)

CERTIFICATE OF DEATH

15188

Reg. Diat. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Suburban Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Iowa County: Story
City or town: Ames
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Mrs. Cora Barclay Noble

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Alvin B. Noble
B.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 23, 1863

8. AGE: Years	Months	Days	If less than one day
82	0	8	hrs. min.

9. Birthplace: West Liberty, Iowa (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER — 12. Name: Marcus Barclay
13. Birthplace
MOTHER — 14. Maiden name: Amy Traer
15. Birthplace
18. Informant: Nellie Noble Jones, daughter
Address: 4455 Franklin St., Omaha, Neb.
17. Shipment (Burial, cremation, or removal. Which?) Date thereof 6/2/45 (month) (day) (year)
Cemetery or crematory: College Cem.
Location: Ames, Iowa
18. Funeral director: Wm Reuben Dunphrey
Address: 7557 Wis. Ave. Bethesda
19. 6/2 1945 Wm E Johns Md. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 31 1945, at 6 40 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 20 1945, to May 31 1945 and that I last saw h. alive on May 30 1945

Immediate cause of death	DURATION
Intestinal obstruction (ileum)	11 days
Due to: Adhesions	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Obstruction of bowel as above — Date of op. May 25
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: John Logan M.D. M. D. or other
Address: 6001 Nevada Ave NW — Date signed: May 31 1945

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

105189

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 days
Hospital, institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Md.
How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: N. Y. County:
City or town: Utica
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1213 Capital Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: V

3.(a) FULL NAME: O'NEILL, Rita Agnes, Slc V-10 USNR

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W-US	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 11-7-22

8. AGE: Years: 22 | Months: 6 | Days: 11 | If less than one day: hrs. min.

9. Birthplace: N.Y. (Town, county, and state)

10. Usual occupation: Navy

11. Industry or business

FATHER
12. Name: Mr. William O'Neill
13. Birthplace: Ill.

MOTHER
14. Maiden name: Celia Hopkins
15. Birthplace: Ireland

16. Informant: father: Mr. William O'Neill
Address: 1213 Capital Avenue, Uitca, N.Y.

17. removal (Burial, cremation, or removal. Which?) Date thereof: 5-18-45 (month) (day) (year)
Cemetery or crematory: St. Agnes
Location: Utica, N.Y.

18. Funeral director: W. W. Chambers Ret.
Address: 1400 Chapin St., N. W., Wash., D.C.

19. 5-18- 45 (Date rec'd by registrar) Registrar: mary Charlotte Smith

MEDICAL CERTIFICATION

20. DATE OF DEATH: 18 May 1945, at 5:10a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7 May 1945, to 18 May 1945
and that I last saw her alive on 17 May 1945

Immediate cause of death	DURATION
TUBERCULOUS MENINGITIS	16 days
Due to	
Due to	
Diher conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: B. F. ECKARDT, Lt. (MC) USNR
Address: U.S.Naval Hospital, Bethesda, Md. M. D. or other
Date signed: 5-18-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (173)

CERTIFICATE OF DEATH

T5190

Reg. Dist. No. 214

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring (Outside)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Died instantly
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Ohio County: Hamilton
City or town: Cincinnati
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6247 Orchard Lane
(If rural, give LOCATION)
2.(a) If veteran, name war: World War II ✓

3.(a) FULL NAME: Col. Dudley M. Outcalt

3.(b) Social Security Number: 0-165317

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	MARRIED

6.(b) Name of husband or wife: Louisa C. Outcalt
6.(c) If alive, give age: 42 years

7. Birth date of deceased (mo., day, yr.): March 8 1897

8. AGE: Years	Months	Days	If less than one day
48	2	18	....hrs. ....min.

9. Birthplace: Cincinnati Ohio (Town, county, and state)
10. Usual occupation: Attorney at Law
11. Industry or business: Legal
FATHER 12. Name: Dudley C. Outcalt
13. Birthplace: Cincinnati, Ohio
MOTHER 14. Maiden name: Mary L. Black
15. Birthplace: Cincinnati
16. Informant
Address
17. Removal (Burial, cremation, or removal. Which?) Date thereof May 29 1945 (month) (day) (year)
Cemetery or crematory
Location: Cincinnati Ohio
18. Funeral director: Wasstler Funeral Home
Address: 301 E. Capitol St. Wash. DC
19. May 28 1945 (Date rec'd by registrar) Josephine McElhaffe (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 26 1945, at 1:25 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec. Med. Exam 19.... to ....19....
and that I last saw h... alive on ....19....

Immediate cause of death	DURATION
Compound fracture L. skull with multiple body bruises	died instantly
Due to: Lacerating conjunction	
Due to: aeroplane accident	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accidental Date of 5-26-45
Where did injury occur? Silver Spring (City or town) Monty (County) Md (State)
Injured at home, farm, industry, public place (where?): air
Means of injury: aeroplane Injured at work? yes

23. SIGNATURE: Frank J. Bronhart M.D. M. D. or other
Address: Gaithersburg Md. Date signed: 5-27-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

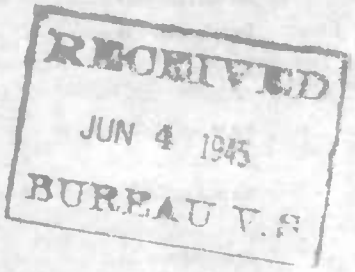
MARGIN RESERVED FOR BINDING

27 May 1945

Released to US Army Authorities, Washington, DC

Frank J Broschart

FRANK J BROSCHART, MD
Deputy Medical Examiner
for Montgomery County, Md



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

CERTIFICATE OF DEATH

Reg. Dist. No. 223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, institution, or street address where death occurred:
Washington Sanitarium

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: ..... County: .....

City or town: Washington D.C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1207 Gallatin St. N.W. Wash. D.C.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Robert M. Pindell

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife: Lida G. Pindell

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 6 1870

8. AGE: Years	Months	Days	If less than one day
74	8	6	..... hrs. ..... min.

9. Birthplace: Pindell Md.
(Town, county, and state)

10. Usual occupation: .....

11. Industry or business: Heather business - Retired

FATHER
12. Name: Robert M. Pindell
13. Birthplace: Pindell, Md.

MOTHER
14. Maiden name: Mary Frances Pindell
15. Birthplace: Pindell, Md

16. Informant: Daughter - Frances E Pindell

Address: 1207 Gallatin St. N.W. Wash. D.C.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 5/13/45 (month) (day) (year)

Cemetery or crematory: .....

Location: Washington D.C.

18. Funeral director: M. J. Gorkle

Address: 510 - C St. N.E.

19. 5/13/45 (Date rec'd by registrar) Registrar: J. Willis Rod

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13 1945 at 1:25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 9 1945, to May 13 1945 and that I last saw h.i.m. alive on May 13 1945

Immediate cause of death	DURATION
Myocardial Insufficiency	?
Due to: Arteriosclerosis	?
Due to:	5 days
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: 0

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Chas. A. Hobbs M.D

Address: 500 Rhode Island Ave N.W. M. D. or other

Date signed 5/13/45

MARYLAND STATE DEPARTMENT OF HEALTH

05192

2411 N. Charles St., Baltimore (173)

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring (outside)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Fatal instantly
Hospital, Institution, or street address where death occurred:
—
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: DC County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1320 Eastern Ave. N.E.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War II ✓

3.(a) FULL NAME: S/Sgt Frank A Pogorelski

3.(b) Social Security Number: 13005 320

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Justine P.
6.(c) If alive, give age: 24 years

7. Birth date of deceased (mo., day, yr.): October 21, 1920

8. AGE: Years	Months	Days	If less than one day
24	7	5	...hrs. ...min.

9. Birthplace: THROOP Pa.
(Town, county, and state)
10. Usual occupation: SOLDIER
11. Industry or business
FATHER 12. Name: VICTOR Pogorelski
13. Birthplace: Bagna Poland
MOTHER 14. Maiden name: Bertha Pogorelski
15. Birthplace: Kalinowka, Poland
16. Informant
Address
17. Removal (Burial, cremation, or removal. Which?) Date thereof May 29 1945 (month) (day) (year)
Cemetery or crematory
Location: Throop Pa.
18. Funeral director: Wastler Funeral Home
Address: 301 E. Capitol St. Wash. D.C.
19. May 28 1945 (Date rec'd by registrar) Josephine McSchaffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 26 1945, at 1:25 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Dec 1 Med Exam 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Compound fracture of skull with multiple body and	died instantly
Due to extensive injuries	
Due to Aeroplane accident	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accidental Date of 5-26-45
Where did injury occur? Silver Spring (City or town) Montg. (County) Md. (State)
Injured at home, farm, industry, public place (where?): air
Means of injury: Aeroplane Injured at work? Yes

23. SIGNATURE: Frank J. Bosschart M.D.
Dir. Med Exams M. D. or other
Address: Gaithersburg Md. Date signed 5-27-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

27 May 1945

Released to US Army Authorities, Washington, DC

Frank J. Broschart

FRANK J BROSCHART, MD
Deputy Medical Examiner
for Montgomery County, Md

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (54)

05193

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months & 18 days

Hospital, Institution, or street address where death occurred:

US Naval Hospital, Bethesda, Maryland

How long in hospital or institution? 4 months & 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State D.C. County

City or town Washington, D. C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2038 18th St., N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME PYE, Charles Thaddus, Slc V6 SV USNR

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 11 October 1917

8. AGE: Years	Months	Days	If less than one day
27	7	13	..... hrs. ..... min.

9. Birthplace Washington, D. C.
(Town, county, and state)

10. Usual occupation Navy

11. Industry or business

FATHER 12. Name Thomas Pye (deceased)

13. Birthplace Virginia

MOTHER 14. Maiden name Maude Brown

15. Birthplace Washington, D. C.

16. Informant Mother: Mrs. Maude Louise Stewart

Address 2038 18th Street, N. W., Wash., D. C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 5-28-45 (month) (day) (year)

Cemetery or crematory Arlington National

Location Arlington, Virginia

18. Funeral director L. E. Murray and Son

Address 1337 10th Street N.W., Wash., D. C.

19. 5 - 24 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 24 May 1945, at 6:06a M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 6 January 1945, to 24 May 1945 and that I last saw him alive on 24 May 1945

Immediate cause of death	DURATION
Pulmonary Embolism	
Due to Rheumatic Heart Disease.	
Due to	
Other conditions Pulmonary congestion	

(Include pregnancy within 3 months of death)

Major findings of operations 0

Date of op. 0

Autopsy results 0

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE C Blimson, M. D. or other

Address National Naval Medical Center Date signed 24 May 45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (56)

05194

CERTIFICATE OF DEATH

Reg. Dist. No. 213

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH.

County Montgomery

City or town Rockville

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 109 Forest Ave.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 25 years.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Montgomery

City or town Rockville Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Grace Reed.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	Widowed

8 (b) Name of husband or wife Grafton Reed.

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Oct 30 - 1879

8. AGE:

Years	Months	Days	If less than one day
65	7		____ hrs. ____ min.

9. Birthplace Washington D.C.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER

12. Name Julius Emmer

13. Birthplace Poland.

MOTHER

14. Maiden name Elizabeth Vitt

15. Birthplace Germany.

16. Informant Mrs. Emma Eckert.

Address 3907 - Newton St. Brentwood Md.

17. removal. Date thereof May 11 - 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director W.W. Chambers Co.

Address 1400 Chapin St. N.W., Wash, D.C.

19. 5/11/45 Josephine D. Hatton

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1945, at 2:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1944, to May 11 1945, and that I last saw her alive on May 10 1945.

	DURATION
Immediate cause of death Acute dilatation of heart	2 days
Due to Brain tumor, benign. Duration: Known symptoms for six months.	
Due to Cause?	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. J. Hartley M.D. M. D. or other

Address Rockville, Md. Date signed 5/11/45

*Evidence for corrections shown on Film G94 5/12/45 DM

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05195 T

Reg. Diat. No. 218

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Gaithersburg Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Two Weeks

Hospital, institution, or street address where death occurred: Summit Ave. *Folks Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2440-16 St. N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME *Reinberg Jacob Reinberg

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White Hebrew	Widowed

6.(b) Name of husband or wife: Rickey *Reinberg

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 3rd 1853

8. AGE:

Years	Months	Days	If less than one day
89	6	29	hrs. min.

9. Birthplace: Lancaster Pa.
(Town, county, and state)

10. Usual occupation: Formerly Whole-Salemerchant

11. Industry or business: Whole Sale Shoe Merchant

FATHER
12. Name: *Daniel Reinberg
13. Birthplace: Baltimore Md

MOTHER
14. Maiden name: Unknown
15. Birthplace: *Henry Reinberg

18. Informant: *Nord Reinberg

Address: *2537 Linden Ave. Baltimore

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/3/45 (month) (day) (year)

Cemetery or crematory: Baltimore Hebrew

Location: Blair Rd - Baltimore Md

18. Funeral director: David Goodman & Sons

Address: 1902 Eutaw Pl. Baltimore

19. May 2 1945 Abeda G. Artz 2nd
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 2nd 1945, at 99 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 23 1945, to May 2 1945

and that I last saw h alive on May 1st 1945

Immediate cause of death: Chronic Myocarditis

Due to: Myocardial Failure

Due to: Fatty Myocardial Decompensation

Due to: General arterio Sclerosis ?

Other conditions:

(Include pregnancy within 3 months of death)

DURATION
15 yrs
3 Wks

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Upton D Lawrence M.D
M. D. or other

Address: Gaithersville Md. Date signed: 5-2-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15)

CERTIFICATE OF DEATH

05196

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months, 6 days

Hospital, Institution, or street address where death occurred:
U.S. Naval Hospital, Bethesda, Md.

How long in hospital or institution? 2 months, 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Tenn. County:

City or town: McMinnville, Tenn.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: no street address
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: REYNOLDS, Frank Deakins, PhM2c V-6 USNR

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife:

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 8 April 1925

8. AGE: Years	Months	Days	If less than one day
20	0	26	..... hrs. ..... min.

9. Birthplace: Tenn. (Town, county, and state)

10. Usual occupation: Navy

11. Industry or business:

FATHER
12. Name: Frank Reynolds
13. Birthplace: Tenn. (deceased)

MOTHER
14. Maiden name: Marguerite F. Crck
15. Birthplace: Tenn.

16. Informant: Mother: Marguerite Reynolds DILLON
Address: McMinnville, Tenn.

17. removal (Burial, cremation, or removal. Which?) Date thereof 5-4-45 (month) (day) (year)

Cemetery or crematory: Mountainview

Location: McMinnville, Tenn.

18. Funeral director: W. W. Chambers, per R. E. Tolar
Address: 1400 Chapin St., N. W., Wash., D.C.

19. 5-4 (Date rec'd by registrar) 19 45 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 4 19 45, at 8:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 28 Feb. 19 45, to 4 May 19 45 and that I last saw him alive on 4 May 19 45

	DURATION
Immediate cause of death: cardiac Failure	
Due to: Nasopharyngitis Ulcerative acute	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: US N.H., Bethesda, Md. Date signed: 5-4-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83)

CERTIFICATE OF DEATH

T

05197 216

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution? 4 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of Columbia County

City or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5400 Allen Road; Friendship Sta.

(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME Maude B Robinson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	white	

6.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) June 11, 1872

8. AGE: Years	Months	Days	If less than one day
72	11	10	____ hrs. ____ min.

9. Birthplace Kansas

(Town, county, and state)

10. Usual occupation — — — —

11. Industry or business

FATHER 12. Name Braguniier

13. Birthplace — — — —

MOTHER 14. Maiden name — — — —

15. Birthplace — — — —

16. Informant Hospital Records

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof 5-21-45 (month) (day) (year)

Cemetery or crematory Galveston - Texas

Location Wash. D.C.

18. Funeral director The S. H. Hines Co.

Address 0901 - 14th St. N.W.

19. 5-21-45 (Date rec'd by registrar) 19 ____ W E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 21 May 1945 19 ____, at ____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 17 May 45 19 ____, to 24 May 19 45

and that I last saw her alive on 21 May 1945 19 ____

Immediate cause of death	DURATION
Subarachnoid Hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. ____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE Charles R Hall M.D.

M. D. or other

Address 1801 Eye St N.W. Wash. D.C. Date signed 24 May 1945

05198

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Suburban Hospital
How long in hospital or institution? 25 Hours - 25 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Maryland County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4400 East West Highway
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Joseph Gerald Lumburg

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 16, 1945 @ 8:20 pm

8. AGE: Years	Months	Days	If less than one day
			1 hrs. 25 min.

9. Birthplace: Bethesda Montgomery Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Joseph Clyde Lumburg Jr
13. Birthplace: Ophir, Colorado

MOTHER
14. Maiden name: Grace Marie McGee
15. Birthplace: Rockport, Missouri

16. Informant
Address

17. (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
Cemetery or crematory
Location

18. Funeral director
Address

19. 5/22/1945 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 17, 1945 at 9:45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 16, 1945, to May 17, 1945 and that I last saw him alive on May 17, 1945

Immediate cause of death	DURATION
Unknown.	
Premature birth	
Due to 5 month gestation	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

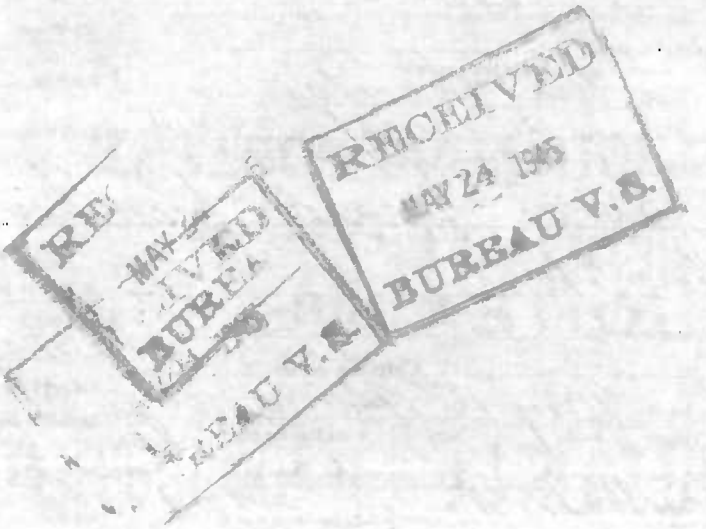
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: E. A. Drew M. D. ~~or other~~
Address: Bethesda Md Date signed: 5-19-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15


RECEIVED
MAY 24 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (4)

05199

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:
County Montgomery
City or town Takoma Park md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State md County Montgomery
City or town Takoma Pk. md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 100 Baltimore, Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Bertha - Ryan

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow

6.(b) Name of husband or wife William T. Ryan
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 22 1877.

8. AGE: Years	Months	Days	If less than one day
67			..... hrs. ..... min.

8. Birthplace Wash DC.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Andrew G. Rise
13. Birthplace Baltimore md.
MOTHER 14. Maiden name Bertha Straby
15. Birthplace Baltimore Md.
16. Informant Mrs Mildred Daw.
Address Tudor Hall apt. Wash. DC.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/18/1945. (month) (day) (year)
Cemetery or crematory Matthews, Friendship Cemetery
Location Matthews, Va.
18. Funeral director W.W. Chambs Co
Address Riverdale md.
19. May 18 1945 Josephine M. Schaffle Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-18 1945 at 8:25 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1943 to 5-18 1945
and that I last saw him alive on 5-15 1945

	DURATION
Immediate cause of death Acute Cardiac Failure	
Due to Arteriosclerosis	yrs.
Due to	
Other conditions Diabetes	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. M. Hamer M.D.
M. D. or other
Address Silver Spring, md. Date signed 5-18-45

(M) MARGIN RESERVED FOR BINDING (1)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (7)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Suburban Hospital
How long in hospital or institution? 1 hour 20 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No. 505 Taylor St
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mrs Daisy Schenck

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6, 1879

8. AGE:

Years	Months	Days	If less than one day
66	1	4	hrs. min.

9. Birthplace Washington, D.C. (Town, county, and state)
10. Usual occupation none
11. Industry or business

FATHER
12. Name John Price
13. Birthplace Unknown

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Hospital Records.
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof 5/11/45 (month) (day) (year)

Cemetery or crematory
Location

18. Funeral director W. W. Saunders Co
Address 1400 Chapin St

19. 5/11 19 45 Wm E Jobes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/11 19 45 at 12 10 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb 1 19 45 to May 11 19 45
and that I last saw h. alive on May 11 19 45

Immediate cause of death — DURATION
Coronary occlusion — 1 day
Heart block (complete) — 1 day
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John Logan M.D.
M. D. or other
Address 600 Nwalnut Ave Date signed May 11-1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (14)

CERTIFICATE OF DEATH

05201

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Suburban Hospital

How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: County:

City or town: Washington D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4550 Conn. Ave. N.W. Apt. 511

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Mrs. Mary Schoenborn

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widow

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mar. 11, 1874

8. AGE: Years: 71 | Months: 1 | Days: 24 | If less than one day: hrs. min.

8. Birthplace: St. Mary's Co. Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Daniel Goldsmith Shawler

13. Birthplace: Md.

MOTHER — 14. Maiden name: Mary Mildred Goldsmith

15. Birthplace: Virginia

16. Informant: Frances Rose (daughter)

Address:

17. (Burial, cremation, or removal. Which?) Removal Date thereof 5/6/45 (month) (day) (year)

Cemetery or crematory:

Location:

18. Funeral director: Upshur Co.

Address: 2901 - 14th St N W

19. 5/6 1945 (Date rec'd by registrar) Wm E Jobe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 5, 1945 at 5:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1 1945, to May 5 1945 and that I last saw h.. alive on May 5, 1945

Immediate cause of death: Congestive Heart Failure — DURATION: 24 hr.

Due to: Leukemia, chronic — 2 yrs.

Due to: Leukemia stage

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: Leukemia, chronic

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Sidney C. Lawrence, M.D. M. D. or other

Address: 3921 Livingston St. Date signed: 5/5/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 ✓

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

T 05202

Reg. Dist. No. 214

1. PLACE OF DEATH:

County: Montg

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Va. County:

City or town: Fredericksburg (Outside)

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Minnie Scott

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: William M Scott

6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): Mar. 15 1900

8. AGE:

Years	Months	Days	If less than one day
45	2	14	hrs. min.

9. Birthplace: Stafford Co. Va.

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Benjamin McKenney

13. Birthplace: Stafford Co. Va.

MOTHER — 14. Maiden name: Embly

15. Birthplace: Stafford Co. Va.

16. Informant: Gertrude Smith (Sister)

Address: Oswego Ave. Takoma Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 3 1945 (month) (day) (year)

Cemetery or crematory: Stafford Co. Va.

Location: Stafford Co. Va.

18. Funeral director: Albert L. Snowden

Address: 246 N. Wash. St. Rockville Md.

19. May 30 1945 (Date rec'd by registrar) Josephine M. Schaeffe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 30 1945; at 10:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. Med. Exam. Case 19, to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Cerebral Hemorrhage	15 min.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank J. Brockhart M.D. Dep. Med. Exam. M. D. or other

Address: Fredericksburg, Md. Date signed: 5-30-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

05203

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery County
City or town Chevy Chase
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
8 East Melrose St.
Stay in hospital or insf. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Chevy Chase Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 8 East Melrose St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Henry Wireman Sohon.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Annietta Emily Gibson Sohon
6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) March 10, 1864

8. AGE:

Years	Months	Days	If less than one day
81	2	12	____hrs. ____min.

9. Birthplace San Franscisco, California
(Town, county, and state)

10. Usual occupation Lawyer.

11. Industry or business N

FATHER
12. Name Gustav Sohon.
13. Birthplace Germany

MOTHER
14. Maiden name Julia Groh
15. Birthplace Germany

16. Informant Elizabeth Sohon
Address 8 East Melrose St, Chevy Chase Md.

17. ____ (Burial, ~~cremation~~, or removal. Which?) Date thereof 5 24 1945 (month) (day) (year)

Cemetery or crematory Mt. Olivet, Rock Cr.

Location

18. Funeral director P. J. Stoffell

Address 475-K. St. N.W.

19. 5/24 1945 (Date rec'd by registrar) Mrs E. Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1945, at 7.15 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5 1945, to May 22 1945, and that I last saw him alive on May 21 1945.

	DURATION
Immediate cause of death Senility	
Due to Arteriosclerosis	1 year
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. Winthrop Peabody M.D.
M. D. or other
Address 1746 K St. N.W. Date signed May 22 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (37-a)

CERTIFICATE OF DEATH

T 05205

Reg. Dist. No. 217

1. PLACE OF DEATH:
County: Montgomery
City or town: Olney
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred: Montgomery Co Gen Hosp
How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town: Olney Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Robert A Sopher

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Mary V. Sopher
6.(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.): 3/19/1875

8. AGE:

Years	Months	Days	If less than one day
70	2	6	...hrs. ...min.

9. Birthplace: Md. (Town, county, and state)
10. Usual occupation: Merchant
11. Industry or business: —

FATHER
12. Name: Th. W. Sopher
13. Birthplace: Maryland

MOTHER
14. Maiden name: Rachael Kemp
15. Birthplace: Md

16. Informant: Mrs R P Sopher
Address: Olney Md

17. Burial (Burial, cremation, or removal, which?) Date thereof May 29 1945 (month) (day) (year)
Cemetery or crematory: St Johns Olney
Location: Montgomery Co Md
18. Funeral director: Roy W. Barber
Address: Laytonsville Md

19. 5-29- 1945 (Date rec'd by registrar) Gertrude K. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5/26/ 1945 at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/13/ 1945, to 5/26/ 1945 and that I last saw him alive on 5/20/ 1945

Immediate cause of death	DURATION
Cerebral Embolism	1 hr
Due to: Hypertensive Dis	2 yrs
Due to: Late	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Coagulosy
Date of op. 5/23/45
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work? —

23. SIGNATURE: J M B'l M. D. or other
Address: Sandy Spring Md Date signed 5/29/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (11-4)

CERTIFICATE OF DEATH

05204

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? one month 22 days

Hospital, Institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Md.

How long in hospital or institution? one month twenty-two days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: N.C. County:

City or town: Durham
(If outside city or town limits, write RURAL and give nearest town)

Street No. 421 Bailey St.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War 2 ✓

3.(a) FULL NAME: SOUTHERLAND, Arthur Delk, V.B.P.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 29 April 1918

8. AGE: Years	Months	Days	If less than one day
27	0	8	hrs. min.

9. Birthplace: N. C. (Town, county, and state)

10. Usual occupation: Truck for Dry Cleaning Establishment

11. Industry or business:

FATHER
12. Name: Dan Southerland
13. Birthplace: N.C. (deceased)

MOTHER
14. Maiden name: Vinnie Woody
15. Birthplace: N. C. (

16. Informant: Mo: Mrs. Vinnie (n) Southerland
Address: 421 Bailey St., Durham, N. C.

17. removal (Burial, cremation, or removal. Which?) Date thereof 5-8-45 (month) (day) (year)

Cemetery or crematory: BeachWood

Location: Durham, N. C.

18. Funeral director: W. Ernest Jarvis E.W.J.

Address: 1332 U St., N. W., Wash., D.C.

19. 5-8 19 45 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 8 1945, at 11:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 16 March 1945, to 8 May 1945 and that I last saw him alive on 8 May 1945

	DURATION
Immediate cause of death: Abscess, Multiple, Right Lung	9 mos.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Abscess, Multiple, R. Lung. Date of op. 5-8-45

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured of work?

23. SIGNATURE: E. M. Kent E. M. KENT, Lt. Comdr. (MC) USNR
M. D. or other

Address: USNH, Bethesda, Md. Date signed: 5-8-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

05206

Reg. Diat. No. 113

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Geo MONTGOMERY
City or town: Lokoma Park Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: MONTGOMERY
City or town: Lokoma Park Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 37 Poplar Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Carrie Elizabeth Tabb

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife: Edgar M. Tabb
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): May 3, 1881

8. AGE: Years	Months	Days	If less than one day
63			hrs. min.

9. Birthplace: Va (Town, county, and state)
10. Usual occupation: at home
11. Industry or business
FATHER 12. Name: Henry Van Leventer
13. Birthplace: Va
MOTHER 14. Maiden name: Elza B Van Leventer
15. Birthplace: Va
16. Informant: Edgar M Tabb
Address: Lokoma Park Md
17. Removal (Burial, cremation, or removal. Which?) Date thereof May 14, 1945 (month) (day) (year)
Cemetery or crematory: Gaeck Funeral Home
Location: Hyattsville Md
18. Funeral director: E Gaeck & sons
Address: Hyattsville Md
19. 5-14 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 14 1945, at 7 a. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 4, 1945, to May 14, 1945
and that I last saw h- alive on May 13 1945

Immediate cause of death	DURATION
Arterio - sclerosis	Indefinite
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: 6911 5th St. N.W. Washington D.C. Date signed May 14/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05207

Reg. Dist. No. 214

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred:
408 Lanark Way

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. 408 Lanark Way
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Hilda Elizabeth Thompson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Leroy Thompson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 18, 1916

8. AGE: Years: 29 Months: 4 Days: — If less than one day: ..... hrs. ..... min.

9. Birthplace: Colesville, Montgomery Co., Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER — 12. Name: Jerry N. Hobbs

FATHER — 13. Birthplace: Boyton, Howard Co. Md.

MOTHER — 14. Maiden name: Margaret Baker

MOTHER — 15. Birthplace: Maryland

16. Informant: C. Leroy Thompson

Address: 408 Lanark Way

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 20 1945 (death) (day) (year)

Cemetery or crematory: Colesville Cemetery

Location: Colesville, Maryland

18. Funeral director: Warner E. Humphreys

Address: Silver Spring, Maryland

19. May 20 1945 (Date rec'd by registrar) Josephine M. Schaeffle Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 18 1945 at 12:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1 1944, to May 18 1945.

and that I last saw her alive on May 17 1945.

	DURATION
Immediate cause of death: Broncho-pneumonia	3 days
Due to: Infantile paralysis	7½ mts
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE: [signature] M. D. or other

Address: Sandy Spring, Md. Date signed: 5/19/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-e)

CERTIFICATE OF DEATH

T 5208

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Montgomery
City or town: R.F.D. Gaithersburg Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Rural Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Hazel B. Tompkins

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Jame E Tompkins
6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): July 22, 1909

8. AGE: Years	Months	Days	If less than one day
36	10	4	hrs. min.

9. Birthplace: Fairview Washington County (Town, county, and state)
10. Usual occupation: Home Wife
11. Industry or business: Farm

FATHER
12. Name: Daniel R Shuff
13. Birthplace: Washington Co. Md

MOTHER
14. Maiden name: Blanch J Zimmerman
15. Birthplace: Washington Co Md

16. Informant: Jame E Tompkins
Address: Gaithersburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 31 1945 (month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location: Prince George County
18. Funeral director: Roy W Barber
Address: Laytonsville Md
19. 5/30/45 (Date rec'd by registrar) H O Bell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 26 1945, at 2:45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1944 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Intracranial Hemorrhage	Called instantly
Due to: Fracture of skull (accidental)	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 5-26-45
Where did injury occur? Gaithersburg (City or town) R.F.D. (County) Monty (State) Md
Injured at home, farm, industry, public place (where?): highway
Means of injury: automobile Injured at work? no

23. SIGNATURE: Frank J Brochaut M.D. M. D. or other
Address: Gaithersburg Md Date signed 5-26-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

052097

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83(a)

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?:
~~No. (If in hospital or institution, give~~ or street address where death occurred:
10226 Colesville Road
How long in hospital or institution?:

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 10226 Colesville Road
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: ERNEST H. TROSTLE

3.(b) Social Security Number: 183-07-4614.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Ida R.
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): October 9th. 1878

8. AGE: Years	Months	Days	If less than one day
66	6	23	..... hrs. ..... min.

9. Birthplace: Adams Co. Penna
(Town, county, and state)
10. Usual occupation: Real Estate Salesman
11. Industry or business

FATHER
12. Name: Joseph W. Trostle
13. Birthplace: Adams Co. Penna.

MOTHER
14. Maiden name: Cordelia Murtorff
15. Birthplace: Cumberland Co. Penna.

16. Informant: Mrs. Ida R. Trostle, wife
Address: 10226 Colesville Rd. Silver Spring.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 5th. 1945 (month) (day) (year)
Cemetery or crematory: Cedar Hill Cemetery
Location: Suitland, Pr. Georges Co. Md.

18. Funeral director: Wame E Pumphrey
Address: 8434 Ga. Ave. Silver Spring, Md.

19. May x 1945 (Date rec'd by registrar) Josephine M. Schaffle Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 2 1945 at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 20 1945 to May 1 1945
and that I last saw him alive on Apr 29 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 mo
Due to: Hypertension	several years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: John H. Andrews Jr. & M. D. or other
Address: 9601 Colesville Rd Silver Spring Md. Date signed: 5-2-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15


RECEIVED
MAY 14 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92d)

CERTIFICATE OF DEATH

05212

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Va County: Arlington
City or town: Arlington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2836 Jefferson Davis Highway
(If rural, give LOCATION)
2.(a) If veteran, name war: V

3.(a) FULL NAME: TRUSSELL, Virgie Lena,

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W-US	married

6.(b) Name of husband or wife: William A. Trussell, MoMM3c USNR
6.(c) If alive, give age: ____ years
7. Birth date of deceased (mo., day, yr.): 18 July 1917

8. AGE: Years	Months	Days	If less than one day
27	10	7	____ hrs. ____ min.

9. Birthplace: Va. (Town, county, and state)
10. Usual occupation: housewife
11. Industry or business:

FATHER
12. Name: George Wesley Waddell
13. Birthplace: Va. (deceased)

MOTHER
14. Maiden name: Julie E. Rutherford
15. Birthplace: Va. (deceased)

16. Informant: husband: William A. Trussell, MoMM3c
Address: Naval Air Station, Key West, Florida

17. removal (Burial, cremation, or removal. Which?) Date thereof 5-25-45 (month) (day) (year)
Cemetery or crematory:
Location: Linden, Va.
18. Funeral director: Royston Undertakers H. R.
Address: Middleburg, Va.

19. 5-25 19 45 (Date rec'd by registrar) mary charlotte smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5-25- 1945, at 10 25 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-22-45 19__, to 5-25 1945 and that I last saw h[er] alive on 5-25- 1945

Immediate cause of death	DURATION
Vascular Heart Disease	2 Months
Due to (a) Rheumatic) with Mitral Stenosis &	
Due to Acute Congestive Failure	1 week.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: Not done
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Gordon R. Lamb M. D. or other
Address: N.N.M.C. - Bethesda Date signed 5-25-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (169)

CERTIFICATE OF DEATH

105211

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Monty.
City or town: Enroute from Boyds Md. To Suburban Hy
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Unknown County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Unidentified

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Unknown

6.(b) Name of husband or wife
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
about 30			hrs. min.

9. Birthplace Unknown (Town, county, and state)
10. Usual occupation Unknown
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Non
Address Non-

17. (Burial, cremation, or removal. Which?) Date thereof 5/30/45 (month) (day) (year)
Cemetery or crematory Montgomery Home Cemetery
Location near Rockville Md
18. Funeral director W. Reuben Pumphrey
Address Rockville Md.

19. 6/30 1945 Wm E Dolen Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1945 at 7:50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Def. med Exam 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Fracture of skull and intracranial hemorrhage	
Due to Unknown - Found Along B & O R.R. Tracts about 1½ mi	
Due to West of Boyds Md	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op. 5-7-45
Autopsy results Exam. no autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Unknown Date of
Where did injury occur? Boyds (City or town) Monty (County) Md (State)
Injured at home, farm, industry, public place (where?) Along B & O R.R.
Means of injury Unknown Injured at work?

23. SIGNATURE Frank J. Bouchat M.D
Def. Med Exam
M. D. or other
Address Gaithersburg Md Date signed 5-7-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

CERTIFICATE OF DEATH

~~05-212~~ 052716

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Monty

City or town: Glen Echo Hyts, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 yrs.

Hospital, institution, or street address where death occurred:
6224 Walhonding Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Monty

City or town: Glen Echo Hyts, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 6224 Walhonding Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Benjamen B. Vaden

3.(b) Social Security Number: 578-05-2909

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Sarah Jane

6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): July 23, 1881

8. AGE: Years	Months	Days	If less than one day
63			...hrs. ...min.

9. Birthplace: Va.
(Town, county, and state)

10. Usual occupation: Credit Mgr.

11. Industry or business

FATHER 12. Name: Michael Vaden

13. Birthplace: Tenn.

MOTHER 14. Maiden name: Sarah E. Poole

15. Birthplace: Unknown

16. Informant: Mrs. A.E. Cottingham, Cousin

Address: Potomac, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 6, 1945 (month) (day) (year)

Cemetery or crematory: Potomac Cemetery

Location: Potomac, Md.

18. Funeral director: Wm Reuben Plumphrey

Address: 7551 Wis. Ave. Bethesda, Md.

19. 5/5 1945 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6224 Walhonding Rd. 5-3- 1945, at 7 30 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 4-30- 1945, to 5-3 1945, and that I last saw h... alive on 5-2 1945

Immediate cause of death	DURATION
Cardiac Failure	3 yrs.
Due to: Coronary Thrombosis	4 days
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Eugene N. Higgins M.D.
M. D. or other

Address: 4812 Ellicott St. N.W. Date signed: 5-3 45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

05213

Reg. Dist. No. 2-23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park D. H. D.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? 2½ Mos

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 805 Maple Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: SARAH E. VAN GEUDER

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed

6.(b) Name of husband or wife: March 24 1870

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
75	2			

9. Birthplace: Brookeville, Md.

(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER 12. Name: Jeffreys Whittemore

13. Birthplace: West Va.

MOTHER 14. Maiden name: Catherine Whitting

15. Birthplace: Germany

16. Informant: Mrs. Pauline V. Smith

Address: 133 E. Tyma Ave Pk. D.

17. Burial, cremation, or removal. Which? Burial Date thereof: 5/28/45 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Sullivan Rd.

18. Funeral director: W. H. Chambers Co.

Address: 517-11 St. N.W.

19. (Date rec'd by registrar) May 25 1945

Registered No.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 25th 1945, at 1:00 A.M. Sept.

21. I CERTIFY that the death occurred on the date above stated; that I attended deceased from Sept 8 1936, to May 25 1945

and that I last saw h.er alive on May 12 1945

Immediate cause of death: Thrombosis — Hypertensive cardiac disease — DURATION: 1 month, 9 years

Due to:

Due to:

Other conditions: Parkinsons disease — 3 years

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Henry J. Hadley M.D. M. D. or other

Address: 125-2 Ga. Ave Date signed: 5/25/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

05214 T

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Suburban Hospital

How long in hospital or institution? 2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: P.G.

City or town: Bowie

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME Frederick Weihe

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Miriam

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 4, 1862

8. AGE: Years: 82 | Months: 10 | Days: 5 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER 12. Name: Gottlieb Weihe

FATHER 13. Birthplace: Germany

MOTHER 14. Maiden name: Delius

MOTHER 15. Birthplace: Germany

16. Informant: Mrs. Ruth W. Chase

Address: 435 Raymond St. C.C. Md.

17. Shipment (Burial, cremation, or removal. Which?) Date thereof 5/11/45 (month) (day) (year)

Cemetery or crematory: Newark, Delaware

Location: Newark, Delaware

18. Funeral director: Wm Reuben Dunaghey

Address: 7557 Wis. Ave. Bethesda, Md.

19. 5/11 19 45 (Date rec'd by registrar) W E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 9, 19 45, at 1:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	Heart Failure	DURATION
Due to	Myocardial Infarction	
Due to	Coronary Occlusion	
Other conditions	Arteriosclerosis Generalized Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Coronary Occlusion & Myocardial Infarction

PHYSICIAN: Please underline the cause to which death should be charged statistically

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Richard E Kelso M.D. M. D. or other

Address: Bethesda, Md. Date signed 5-9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

05215

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Montgomery
City or town: Potomac, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Two months, near
Hospital, institution, or street address where death occurred: Rural, on Falls Rd. Potomac, Md.
How long in hospital or institution? not at all.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Dist. of Columbia County:
City or town: 907 - 12th St., S. E.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Washington, D. C.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Sarah Elizabeth Whiteford

3.(b) Social Security Number: Has none.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ~~or wife~~: George Whiteford
6.(c) If alive, give age: dead years
7. Birth date of deceased (mo., day, yr.): Jan. 6 - 1870.

8. AGE:

Years	Months	Days	If less than one day
75	4	23	— hrs. — min.

9. Birthplace: Chambersburg, Pa.
(Town, county, and state)
10. Usual occupation: Housekeeping
11. Industry or business: Home
FATHER 12. Name: Robert Gibbons
13. Birthplace: Penna.
MOTHER 14. Maiden name: Ann Devaine
15. Birthplace: Cumberland, Md.
16. Informant: Ruth Devine
Address: Glen Echo Heights, Md.

17. (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
Cemetery or crematory: Glenwood 6-1-45
Location: Wash. D. C.
18. Funeral director: Geo. W. Wise Co. Inc.
Address: 2900 - M St. Nwd

19. 5-30-45 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 29 1945, at 4:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 8th 1945 to May 29 1945, and that I last saw her alive on May 28 1945

Immediate cause of death	DURATION
Chronic myocardial insufficiency,	3 or 4 years,
Due to Rheumatic carditis,	3 or 4 years,
Due to arteriosclerosis	5 years
Other conditions Senility	5 years

(Include pregnancy within 3 months of death)

Major findings of operations: /
Date of op.: /
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: / Date of: /
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wheeler O Huff M. D.
Address: Bethesda, Md. Date signed: May 29/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 99d

CERTIFICATE OF DEATH

05216 Reg. Diat. No. 213

1. PLACE OF DEATH: Montg

County Chestnut Lodge San

City or town Rockville, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State County

City or town Washington D. C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 820 - 22 nd St. N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Katherine E. Young

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	Married

6.(b) Name of husband or wife Havey O.

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12th 1883 (?)

8. AGE: Years	Months	Days	If less than one day
61 ?			hrs. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Wm. Devers

13. Birthplace Va

MOTHER 14. Maiden name Sarah Javins

15. Birthplace Va.

16. Informant Nellie Colvin (Daughter

Address

17. Burial Date thereof May 24, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill Cem.

Location Maryland.

16. Funeral director The S. H. Hines Co.,

Address 2901- 14th St. N.W.

19. May 23 45 - Josephine D. Holton
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 1945 at 2 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May - 15 1945 to May 23 1945 and that I last saw h alive on May 23 1945

Immediate cause of death	DURATION
Acute Cardiac Dilatation	
Due to Myocarditis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Bernard L. French M.D.
M. D. or other

Address 1726 M St. N.W. Date signed May 23, 45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15